Index of Documents from June Long Term Care Commission Meeting

1. Press Release announcing the appointment of the Office of Long-Term Care Supports and Services Director
2. Letter of congratulations to Mr. Michael Head as Director or the Office of Long-Term Care Supports and Services 6-26-06
3. EXECUTIVE ORDER No. 2004 - 1 Creating the Long-Term Care Task Force
4. Long-Term Care Task Force Recommendations Summary
5. EXECUTIVE ORDER No. 2005 - 14
6. EXECUTIVE ORDER No 2006-4
7. House Bill-5762-3 LTC Continuum
8. House Bill HB 5762 Comparison Grid
9. Request for Letter of Support for the Money Follows the Person Grant Included in the Deficit Reduction Act
10. State Medicaid Director's Letter (from CMS) 060906 Citizenship
11. Citizenship Documentation Provision of Deficit Reduction Act
12. Deficit Reduction Act Citizenship One Page Summary
13. Fact Sheet Regarding Citizenship (CMS)
14. Health and Human Services Issues Citizenship Guidelines For Medicaid Eligibility
15. Michigan State Housing Development Authority Continuing Care Retirement Communities Demonstration 4-26-06
16. Request to the Commission to Provide a Letter of Support for the Medicaid Infrastructure Grant
17. Draft Letter of Support for the Medicaid Infrastructure Grant
18. Press Release for Single Points of Entry 6-5-06
19. House Bill 5389-SR-1 Single Points of Entry
20. Health Care Association of Michigan Response to HB 5389-SR-1
21. Themed Health Care Association of Michigan Issues 6-21-06
22. AARP Letter Regarding House Bill 5389
23. AARP Letter to Long-Term Care Commission 6-15-06
24. Paraprofessional Healthcare Institute - Health Care for Health Care Workers
25. Paraprofessional Healthcare Institute Template - Progress Report of Long-Term Care Task Force Recommendations

www.michigan.gov
(To Print: use your browser's print function)
Release Date: June 19, 2006
Last Update: June 19, 2006

Contact: T.J. Bucholz (517) 241-2112
Agency: Community Health

Head Named Director Of State's New Long Term Care Office

June 19, 2006

Michigan Department of Community Health (MDCH) Director Janet Olszewski has named Michael J. Head as the new director of the Office of Long Term Care Supports and Services.

"Mike brings a wealth of experience to this newly created position in state government," Olszewski said. "Under Mike's direction, the Office of Long Term Care Supports and Services will help to ensure that seniors and our most vulnerable citizens are protected and cared for throughout Michigan."

In June 2005, Granholm accepted recommendations from her 21-member Medicaid Long Term Care Task Force that called for the creation of the office. On the same day she accepted those recommendations, Granholm also signed an Executive Order that created the Long Term Care Supports and Services Office – which will assist in the development and implementation of policy and strategies for the task force recommendations.

The office will coordinate Michigan's state-supported long term care supports and services efforts. The office will be part of the Michigan Department of Community Health (MDCH), which is responsible for reviewing and implementing the task force recommendations.

Since 2003, Head has led the MDCH Office of Consumer-Directed Home and Community-Based Services, which has served as MDCH's Olmstead coordinator and manages several federal Real Choice Systems Change grant projects important to achieving a transformation in long-term care.

Head has more than 30 years of experience in the public mental health and human services field. He has served as a clinician, an administrator, a legislative specialist and as a leader in public policy and systems change at the state and local agency levels. He holds a B.S. in chemistry from the University of Michigan and a Masters of Social Work from Michigan State University.

Head began his career in state government as a mental health consultant to the Michigan Legislature in the 1970s and subsequently for former Michigan Governor William Milliken. He served as Executive Director for two Michigan community mental health programs, and was extensively involved in shaping policy for Michigan's community placement programs and with the design and financing of Michigan's community mental health system.

Beginning in 1997, he led Michigan's Self-Determination Initiative, an option allowing opportunity for consumer/family control over services for persons with developmental disabilities, funded through the Robert Wood Johnson Foundation. This effort culminated in the 2004 adoption of a system-wide requirement supporting consumer access to arrangements that support self-determination as a matter of state policy in the Michigan community mental health system.

Head, 59, is a resident of Pinckney.

The executive order also created a Long Term Care Supports and Services Advisory Commission that will provide guidance and advice to the Long Term Care Supports and Services Office. More than 50 percent of the commission will be consumers of long term care supports or services.

Over the last four years, Michigan – under the Granholm Administration – has made considerable progress related to long term care issues.

In 2003, Granholm – with strong bi-partisan support – initiated a Freedom to Work "Medicaid buy in" program that allows the disabled on Medicaid to have a job without fear of losing their health insurance.

In 2004, MDCH – in full partnership with the federal Centers for Medicare and Medicaid Services – applied for and received a $5 million grant to strengthen and improve Michigan's long term care criminal background check laws and to provide $1.5 million in additional abuse and neglect training to thousands of Michigan long term care workers.

In 2005, Granholm also announced a Jobs Today initiative to modernize 75 of Michigan's oldest nursing homes and replace them with new models that permit more privacy, dignity, and family friendly designs.

Granholm also created the Elder Abuse and Neglect Task Force to make recommendations to ensure that elder abuse and neglect – as well as financial exploitation – is dealt with in a forceful and effective manner.

In June 2006, keeping true to her promise of improving the state's long term care system, Granholm announced four groundbreaking awards worth $34.83 million over two years for Long Term Care Single Point of Entry (SPE) demonstration sites in Michigan. The establishment of long term care SPEs also was a key recommendation presented to the Governor and the Legislature in the final report of the Medicaid Long Term Care Task Force.

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

June 26, 2006

Michael Head, Director
Office of Long Term Care Supports and Services
Department of Community Health
3423 N. Martin Luther King Jr. Boulevard
Lansing, Michigan 48909

Dear Mike:

On behalf of the Long Term Care Supports and Services Advisory Commission, I congratulate you on your recent appointment as Director of the Office of Long Term Care Supports and Services.

Your passion for improving the lives of vulnerable citizens will be a tremendous asset as we work together to implement the recommendations of the Medicaid Long Term Care Task Force.

I look forward to a long and productive relationship.

Sincerely,

Marsha Moers

Marsha Moers, Chair
LTC Supports and Services Advisory Commission

www.michigan.gov
(To Print: use your browser's print function)
Release Date: April 02, 2004
Last Update: April 02, 2004

EXECUTIVE ORDER No.2004 - 1

MEDICAID LONG-TERM CARE TASK FORCE
DEPARTMENT OF COMMUNITY HEALTH

WHEREAS, Section 1 of Article V of the Michigan Constitution of 1963 vests the executive power of the State of Michigan in the Governor;

WHEREAS, under Section 8 of Article V of the Michigan Constitution of 1963, the Governor is responsible to take care that the laws be faithfully executed;

WHEREAS, Section 1 of 1931 PA 195, MCL 10.51, authorizes and empowers the Governor, at such times and for such purposes as the Governor deems necessary or advisable, to create special advisory bodies consisting of as many members as the Governor deems appropriate;

WHEREAS, Michigan's publicly-supported system of long-term care must focus on the provision of adequate care for consumers in an efficient, effective, and fiscally accountable manner;

WHEREAS, consumers and their families or advocates involved with and most affected by Medicaid long-term care services should be consulted in the decision-making process regarding the provision and funding of long-term care services;

WHEREAS, Michigan's Medicaid long-term care system should seek to achieve timely access to care, foster quality and excellence in service delivery, and promote innovative and cost-effective strategies;

WHEREAS, under an Order and Stipulation for Settlement entered by the United States District Court for the Western District of Michigan in case number 5:02-CV-44, the State of Michigan must create a Medicaid long-term care task force to assist in the development of options for expanding the availability of home-based and community-based long-term care services, and for improving long-term care services;

NOW, THEREFORE, I, Jennifer M. Granholm, Governor of the State of Michigan, by virtue of the authority vested in the Governor under the Michigan Constitution of 1963 and Michigan law, order the following:

I. DEFINITIONS

As used in this Order:

A. "Department of Community Health" means the principal department of state government created as the Department of Mental Health under Section 400 of the Executive Organization Act of 1965, 1965 PA 380, MCL 16.500, and renamed the “Department of Community Health” under Executive Order 1996-1, MCL 330.3101.

B. "Task Force" means the Medicaid Long-Term Care Task Force established with in the Department of Community Health under this Order.

II. ESTABLISHMENT OF MEDICAID LONG-TERM CARE TASK FORCE

A. The Medicaid Long-Term Care Task Force is created as an advisory body within the Department of Community Health.

B. The Task Force shall consist of twenty-one (21) members appointed by the Governor and shall include representatives
of each of the following:

1. Seven (7) persons representing consumers of Medicaid long-term care services or their advocates.

2. Seven (7) persons representing providers of long-term care services.

3. Seven (7) persons representing governmental entities, including at least two (2) members representing state agencies and two (2) members representing legislative entities. A director of a principal department of state government appointed under this paragraph may select a designee from within that department to serve on the Task Force as a designated representative of the director.

C. Members of the Task Force shall serve as members at the pleasure of the Governor.

D. A vacancy on the Task Force shall be filled in the same manner as the original appointment.

III. CHARGE TO THE TASK FORCE

A. The Task Force is advisory in nature and shall:

1. Review existing reports and reviews of the efficiency and effectiveness of the current mechanisms and funding for the provision of Medicaid long-term care services in Michigan and identify consensus recommendations.

2. Examine and report on the current quality of Medicaid long-term care

services in Michigan and make recommendations for improvement in the quality of Medicaid long-term care services and home-based and community-based long-term care services provided in Michigan.

3. Analyze and report on the relationship between state and federal Medicaid long-term care funding and its sustainability over the long term.

4. Identify and recommend benchmarks for measuring successes in this state's provision of Medicaid long-term care services and for expanding options for home-based and community-based long-term care services.

5. Identify and make recommendations to reduce barriers to the creation of and access to an efficient and effective system of a continuum of home-based, community-based, and institutional long-term care services in Michigan.

B. The Task Force shall provide other information, recommendations, or advice as directed by the Governor.

C. The Task Force shall complete its work and issue an interim report on its activities, including any preliminary recommendations by October 1, 2004 to:

1. The Governor.

2. The Chairperson and Minority Vice-Chairperson of the Senate Appropriations Subcommittee for the Department of Community Health

3. The Chairperson and Minority Vice-Chairperson of the House Appropriations Subcommittee on Community Health.

4. The Chairperson and Minority Vice-Chairperson of the Senate Committee on Health Policy.

5. The Chairperson and Minority Vice-Chairperson of the House Committee on Health Policy.

D. The final report and recommendations of the Task Force, including any proposed legislation, shall be presented by April 1, 2005 to:

1. The Governor.

2. The Chairperson and Minority Vice-Chairperson of the Senate Appropriations Subcommittee for the Department of Community Health

3. The Chairperson and Minority Vice-Chairperson of the House

Appropriations Subcommittee on Community Health.

4. The Chairperson and Minority Vice-Chairperson of the Senate Committee on Health Policy.

5. The Chairperson and Minority Vice-Chairperson of the House Committee on Health Policy.

IV. OPERATIONS OF THE TASK FORCE

A. If deemed necessary, the Task Force may promulgate bylaws, not inconsistent with Michigan law and this Order, governing its organization, operation, and procedures. The Task Force may establish committees and subcommittees as it deems advisable.

B. The Governor shall designate one of the members of the Task Force as its Chairperson. The Task Force may select from among its members a Vice-Chairperson and shall select from among its members a Secretary. Task Force staff shall assist the Secretary with record-keeping responsibilities.

C. The Task Force shall meet at the call of the Chairperson and as may be provided in procedures adopted by the Task Force.

D. The Task Force may establish committees and request public participation on advisory panels as it deems necessary. The Task Force may adopt, reject, or modify recommendations made by committees, subcommittees, or advisory panels.

E. The Task Force shall act by majority vote of its serving and voting members. A majority of the members of the Task Force constitutes a quorum for the transaction of business.

F. The Task Force may, as appropriate, make inquiries, studies, investigations, hold hearings, and receive comments from the public. The Task Force may consult with outside experts, consumers, and their families in order to perform its duties.

G. Members of the Task Force shall serve without compensation. Members of the Task Force may receive reimbursement for necessary travel and expenses according to relevant statutes and the rules and procedures of the Department of Management and Budget and the Civil Service Commission, subject to available appropriations.

H. State Departments and agencies shall assist the Task Force as requested and directed by the Governor.

I. On behalf of the Task Force, the Department of Community Health may hire or retain contractors, sub-contractors, advisors, consultants, and agents, and may make and enter into contracts necessary or incidental to the exercise of the powers of the Task Force and

the performance of its duties, as the Department of Community Health deems advisable and necessary in accordance with the relevant statutes, rules, and procedures of the Civil Service Commission and the Department of Management and Budget.

J. On behalf of the Task Force the Department of Community Health may accept donations of labor, services, or other things of value from any public or private agency or person.

K. Members of the Task Force shall refer all legal, legislative, and media contacts to the Department of Community Health.

V. MISCELLANEOUS

A. All departments, committees, commissioners, or officers of this state or of any political subdivision of this state shall give to the Task Force, or to any member or representative of the Task Force, any necessary assistance required by the Task Force, or any member or representative of the Task Force, in the performance of the duties of the Task Force so far as is compatible with its, his, or her duties. Free access shall also be given to any books, records, or documents in its, his, or her custody, relating to matters within the scope of inquiry, study, or investigation of the Task Force.

B. The invalidity of any portion of this Order shall not affect the validity of the remainder the Order.
This Order is effective upon filing.

Given under my hand and the Great Seal of the State of Michigan this 1st day of April in the year of our Lord two thousand and four.

_____
JENNIFER M. GRANHOLM
GOVERNOR

BY THE GOVERNOR:

_____
SECRETARY OF STATE

Michigan Long-Term Care Task Force
Executive Summary of Recommendations

The Michigan Medicaid Long-Term Care Task Force, appointed by Governor Jennifer Granholm, met between June 2004 and May 2005. It was charged with the duty to examine the long-term care (LTC) system and make recommendations to improve quality, expand the reach of home- and community-based services, and reduce barriers to an efficient and effective continuum of LTC services in Michigan. The task force responded by adopting a mission statement that emphasizes the role of consumer choice and by recommending the following policy changes:

1. Require and implement person-centered planning practices throughout the LTC continuum and honor the individual's preferences, choices, and abilities.
2. Improve access by establishing *money follows the person* principles that allow individuals to determine, through an informed choice process, where and how their LTC benefits will be used.
3. Designate locally or regionally-based "Single Point of Entry" (SPE) agencies for consumers of LTC and mandate that applicants for Medicaid funded LTC go through the SPE to apply for services.
4. Strengthen the array of LTC services and supports by removing limits on the settings served by MI Choice waiver services and expanding the list of funded services.
5. Support, implement, and sustain prevention activities through (1) community health principles, (2) caregiver support, and (3) injury control, chronic care management, and palliative care programs that enhance the quality of life, provide person-centered outcomes, and delay or prevent entry into the LTC system.
6. Promote meaningful consumer participation and education in the LTC system by establishing a LTC Commission and informing the public about the available array of options.
7. Establish a new Quality Management System for all LTC programs that includes a consumer advocate and a Long-Term Care Administration that would be responsible for the coordination of policy and practice of long-term care.
8. Build and sustain culturally competent, highly valued, competitively compensated and knowledgeable LTC workforce teams that provide high quality care within a supportive environment and are responsive to consumer needs and choices.
9. Adopt financing structures that maximize resources, promote consumer incentives, and decrease fraud.

Release Date: June 09, 2005
Last Update: June 09, 2005

EXECUTIVE ORDER No.2005 - 14

DEPARTMENT OF COMMUNITY HEALTH
OFFICE OF LONG-TERM CARE SUPPORTS AND SERVICES
MICHIGAN LONG-TERM CARE SUPPORTS AND SERVICES ADVISORY COMMISSION

WHEREAS, Section 1 of Article V of the Michigan Constitution of 1963 vests the executive power of the State of Michigan in the Governor;

WHEREAS, under Section 8 of Article V of the Michigan Constitution of 1963, the Governor is responsible for taking care that the laws be faithfully executed;

WHEREAS, under Section 8 of Article V of the Michigan Constitution of 1963, each principal department of state government is under the supervision of the Governor unless otherwise provided by the Constitution;

WHEREAS, Michigan's publicly-supported system of long-term care must be provided in an integrated and coordinated manner, and must focus on the provision of adequate supports and services, and care for consumers in an efficient, effective, and accountable manner;

WHEREAS, consumers and the families or advocates involved with and most affected by Medicaid long-term care services and supports should be consulted on an on-going basis about ways to improve the quality and delivery of long-term care services and supports;

WHEREAS, Michigan's long-term care system must seek to provide effective public education about the options and settings for long-term services and supports and provide timely and informed access to those options through person-centered planning;

WHEREAS, the Michigan Medicaid Long-Term Care Task Force established by Executive Order 2004- 1, has completed its work and submitted it's final report and recommendations;

WHEREAS, there is a need to take immediate initial steps to begin moving toward the implementation of recommendations made by the Michigan Medicaid Long-Term Care Task Force;

NOW, THEREFORE, I, Jennifer M. Granholm, Governor of the State of Michigan, by virtue of the power and authority vested in the Governor by the Michigan Constitution of 1963 and Michigan law, order the following:

I. DEFINITIONS

As used in this Order:

A. “Commission” means the Michigan Long-Term Care Supports and Services Advisory Commission created within the Department under this Order.

B. “Department of Community Health" or “Department” means the principal department of state government created as the Department of Mental Health under Section 400 of the Executive Organization Act of 1965, 1965 PA 380, MCL 16.500, and renamed the “Department of Community Health” under Executive Order 1996-1, MCL 330.3101.

C. “Office” means the Michigan Office of Long-Term Care Supports and Services created within the Department under this Order.

D. “Office of Services to the Aging” means the Office of Services to the Aging created within the Department of Management and Budget under Section 5 of the Older Michiganians Act, 1981 PA 180, MCL 400.585, and transferred to the Department of Community Health by Executive Order 1997-5, MCL 400.224.

E. “Task Force” means the Michigan Medicaid Long-Term Care Task Force created under Executive Order 2004-1.

II. CREATION OF OFFICE OF LONG-TERM CARE SUPPORTS AND SERVICES

A. The Office of Long-Term Care Supports and Services is created within the Department of Community Health. The authority, powers, duties, and functions of the Office, including, but not limited to, budgeting, procurement, and related management functions, shall be performed under the direction and supervision of the Director of the Department.

B. Staff of the Office shall be designated by the Director of the Department as he or she deems appropriate and sufficient to perform the duties and fulfill the responsibilities of the Office under this Order. The Department initially shall be staff by reallocating resources from the following organizational units or programs within the Department:

1. The Health Policy, Regulation, and Professions Administration of the Bureau of Health Professions.

2. The Health Policy, Regulation, and Professions Administration of the Bureau of Health Services.

3. The Medical Services Administration.

4. The Mental Health and Substance Abuse Services Administration.

5. The Office of Services to the Aging.

C. The Office shall be headed by the Director of the Office of Long-Term Care Supports and Services who shall be a member of the state classified service and report to the Director of the Department.

D. The Office shall do all of the following:

1. Administer activities to implement the recommendations of the Task Force.

2. Coordinate state planning for long-term care supports and services.

3. Review and approve long-term care supports and services policy formulated by state departments and agencies for adoption or implementation.

4. Conduct efficiency, effectiveness, and quality assurance reviews of publicly-funded long-term care programs.

5. Identify and make recommendations to the Director of the Department regarding opportunities to increase consumer supports and services, organizational efficiency, and cost-effectiveness within Michigan's long-term care system.

6. Prepare an annual report for the Director of the Department and the Governor on the progress of implementing the recommendations of the Medicaid Long-Term Care Task Force Report.

7. Oversee the implementation of the single point-of-entry demonstration programs required under Section VI.

E. The Office shall assume the functions performed by the Department's Office of Long-Term Care Supports and Services prior to the effective date of this Order.

III. CREATION OF THE MICHIGAN LONG-TERM CARE SUPPORTS AND SERVICES COMMISSION

A. The Michigan Long-Term Care Supports and Services Advisory Commission is created as an advisory body within the Department as a forum for the discussion of issues relating to the provision of long-term care supports and services in Michigan.

B. The Commission shall consist of 15 members appointed by the Governor, including each of the following:

1. Eight members representing primary or secondary consumers of long-term care supports and services.

2. Three members representing providers of Medicaid-funded long-term care supports and services.

3. Three members representing direct care staff providing long-term care supports and services.

4. One member representing the general public.

C. In addition to the members appointed under Section III.B, the Director of the Department, the Director of the Department of Human Services, the Director of the Department of Labor and Economic Growth, the Director of the Office of Services to the Aging, and the State Long-Term Care Ombudsman, or their designees, shall serve as non-voting ex-officio members of the Commission.

D. Except as otherwise provided in this Section III.D, a member of the Commission appointed under Section III.B shall be appointed to serve for a term of 4 years. To provide for staggered terms, of the members initially appointed under Section III.B, 4 members shall be appointed for a term expiring on May 31, 2006, 4 members shall be appointed for a term expiring on May 31, 2007, 4 members shall be appointed for a term expiring on May 31, 2008, and 3 members shall be appointed for a term expiring on May 31, 2009. A member appointed under Section III.B shall continue to serve until a successor is appointed and qualified.

E. A vacancy on the Commission occurring other than by expiration of a term shall be filled in the same manner as the original appointment for the balance of the unexpired term.

F. The Governor shall designate one of the members of the Commission to serve as its Chairperson. The Commission may select from among its members a Vice-Chairperson.

IV. CHARGE TO THE COMMISSION

A. The Commission shall act in an advisory capacity and shall do all of the following:

1. Review and monitor the implementation of recommendations of the Task Force.

2. Review and comment upon quality assurance reviews of Michigan’s long-term care system.

3. Serve in an effective and visible consumer advocacy role for improving the quality of, and access to, long-term care supports and services.

4. Participate in the preparation and review of an on-going, comprehensive statewide plan and resources plan for long-term care supports and services to address and meet identified consumer preferences and needs.

5. Ensure the broadest possible on-going public participation in statewide planning.

6. Promote broad, culturally competent, and effective public education initiatives about long-term care issues and choices and provide opportunities for direct involvement by the public.

7. Recommend a performance evaluation of the single point of entry demonstration programs required by this Order and make recommendations for the improvement of the single point of entry system in this state.

8. Discuss potential changes in policy that would encourage more effective provision of long-term care supports and services.

B. The Commission shall provide other information, recommendations, or advice relating to long-term care supports and services as requested by the Governor or the Director of the Department.

V. OPERATIONS OF THE COMMISION

A. The Commission shall be staffed and assisted by personnel from the Office, subject to available funding. Any budgeting, procurement, and related management functions of the Commission shall be performed under the direction and supervision of the Director of the Department.

B. The Commission shall adopt procedures consistent with Michigan law and this Order governing its organization and operations.

C. The Commission shall select from among its members a Secretary. Commission staff shall assist the Secretary with recordkeeping responsibilities.

D. A majority of the members serving on the Commission constitutes a quorum for the transaction of the Commission's business. The Commission shall act by a majority vote of its serving members.

E. The Commission shall meet at the call of the Chairperson and as may be provided in procedures adopted by the Commission.

F. The Commission may establish committees and request public participation on workgroups as the Commission deems necessary. The Commission may also adopt, reject, or modify any recommendations proposed by a committee or a workgroup.

G. The Commission may, as appropriate, make inquiries, conduct studies, conduct investigations, hold hearings, and receive comments from the public. The Commission may also consult with outside experts in order to perform its duties, including, but not limited to, experts in the private sector, organized labor, government agencies, and at institutions of

higher education.

H. Members of the Commission shall serve without compensation. Members of the Commission may receive reimbursement for necessary travel and expenses according to relevant statutes and the rules and procedures of the Department of Management and Budget and the Civil Service Commission, subject to available funding.

I. The Commission may hire or retain contractors, sub-contractors, advisors, consultants, and agents, and may make and enter into contracts necessary or incidental to the exercise of the powers of the Commission and the performance of its duties as the Director of the Department deems advisable and necessary, in accordance with this Order, and the relevant statutes, rules, and procedures of the Civil Service Commission and the Department of Management and Budget.

J. The Commission may accept donations of labor, services, or other things of value from any public or private agency or person.

K. Members of the Commission shall refer all legal, legislative, and media contacts to the Department.

VI. SINGLE POINT-OF-ENTRY DEMONSTRATION PROGRAMS

A. By June 30, 2006, the Department shall establish not less than 3 single point-of-entry demonstration programs for the delivery of long-term care supports and services. At least one of the programs must be located in an urban area and at least one of the programs must be located in a rural area.

B. The Department shall conduct evaluations of the efficiency and effectiveness of the demonstration programs in meeting expectations for single point-of-entry initiatives identified in the report issued by the Task Force.

C. In developing the single point-of-entry demonstration programs, the Department shall use a collaborative model. The Office of Services to the Aging and the Department of Human Services shall cooperate with the Department in the implementation of this Section IV.

VII. MISCELLANEOUS

A. All departments, committees, commissioners, or officers of this state or of any political subdivision of this state shall give to the Commission, or to any member or representative of the Commission any necessary assistance required by the Commission, or any member or representative of the Commission, in the performance of the duties of the Commission so far as is compatible with its, his, or her duties. Free access shall also be given to any books, records, or documents in its, his, or her custody, relating to matters within the scope of inquiry, study, or investigation of the Commission.

B. To implement the requirements of this Order, the Director of the Department is authorized to establish the internal organization of the Department and allocate and reallocate duties and functions to promote economic and efficient administration and operation of the Department as authorized by Section 7 of the Executive Organization Act of 1965, 1965 PA 380, MCL 16.107.

C. Nothing in this Order shall be construed to change the organization of the executive branch of state government or the assignment of functions among its units in a manner requiring the force of law pursuant to Section 2 of Article 5 of the Michigan Constitution of 1963.

D. As the Medicaid Long-Term Care Task Force created by Executive Order 2004-1 has completed the work for which it was created, the Task Force is abolished. Executive Order 2004-1 is rescinded in its entirety.

E. Any suit, action, or other proceeding lawfully commenced by, against, or before any entity affected by this Order shall not abate by reason of the taking effect of this Order

F. The invalidity of any portion of this Order shall not affect the validity of the remainder of the Order.

This Order is effective upon filing.

Given under my hand and the Great Seal of the State of Michigan this 9th day of June, in the year of our Lord, two thousand and five.

_____

JENNIFER M. GRANHOLM
GOVERNOR

BY THE GOVERNOR:

_____

SECRETARY OF STATE

www.michigan.gov
(To Print: use your browser's print function)

Release Date: February 14, 2006
Last Update: February 14, 2006

EXECUTIVE ORDER No.2006 - 4

AMENDMENT OF EXECUTIVE ORDER 2005-14
MICHIGAN LONG-TERM CARE SUPPORTS AND SERVICES ADVISORY COMMISSION

WHEREAS, Section 1 of Article V of the Michigan Constitution of 1963 vests the executive power of the State of Michigan in the Governor;

WHEREAS, Section 4 of Article V of the Michigan Constitution of 1963 authorizes the establishment of temporary commissions or agencies for special purposes;

WHEREAS, the Michigan Long-Term Care Supports and Services Advisory Commission was created by Executive Order 2005-14;

WHEREAS, it is necessary and desirable to amend Executive Order 2005-14 to expand the membership of the Advisory Commission;

NOW, THEREFORE, I, Jennifer M. Granholm, Governor of the State of Michigan, by virtue of the power and authority vested in the Governor by the Michigan Constitution of 1963 and Michigan law, order the following:

A. Section III.B of Executive Order 2005-14 is amended to read as follows:

"B. The Commission shall consist of 17 members appointed by the Governor, including each of the following:

1. Nine members representing primary or secondary consumers of long-term care supports and services.

2. Three members representing providers of Medicaid-funded long-term care supports and services.

3. Three members representing direct care staff providing long-term care supports and services.

4. Two members representing the general public."

B. Section III.D of Executive Order 2005-14 is amended to read as follows:

"D. Except as otherwise provided in this Section III.D, a member of the Commission appointed under Section III.B shall be appointed to serve for a term of 4 years. To provide for staggered terms, of the members initially appointed under Section III.B, 4 members shall be appointed for a term expiring on December 31, 2006; 4 members shall be appointed for a term expiring on December 31, 2007; 4 members shall be appointed for a term expiring on December 31, 2008; and 5 members shall be appointed for a term expiring on December 31, 2009. A member appointed under Section III.B shall continue to serve until a successor is appointed and qualified."

This Order is effective upon filing.

Given under my hand and the Great Seal of the State of Michigan this 13th day of February, in the year of our Lord, two thousand and six.

_____
JENNIFER M. GRANHOLM
GOVERNOR

BY THE GOVERNOR:

_____

SECRETARY OF STATE

Legislative Analysis

Mitchell Bean, Director
Phone: (517) 373-8080
http://www.house.mi.gov/hfa

LONG-TERM HEALTH CARE CONTINUUM ACT

House Bill 5762 (Substitute H-2)
Sponsor: Rep. Barbara Vander Veen

House Bill 5919 (Substitute H-1)
Sponsor: Rep. John Stahl
Committee: Senior Health, Security, and Retirement

Complete to 4-26-06

A SUMMARY OF HOUSE BILLS 5762 (H-2) AND 5919 (H-1) AS REPORTED FROM COMMITTEE ON 4-18-06

House Bill 5762 would create the Long-Term Health Care Continuum Act, a new act which would incorporate many provisions currently found in the Public Health Code, as well as provisions from the Adult Foster Care Facility Licensing Act. House Bill 5919 is a companion bill to House Bill 5762 and would revise the Public Health Code to eliminate provisions and make a number of technical revisions to reflect the creation of the Long-Term Health Care Continuum Act. The bill is tie-barred to House Bill 5762, meaning it could not take effect unless House Bill 5762 is enacted.

The new act created by House Bill 5762 contains the following Articles and Parts:

- Article I contains Parts I, which addresses general definitions, and guides to the interpretation and administration of the act, and is said to be modeled on Parts 11 and 12 of the Public Health Code; and Part 3, which would create a new Long-Term Care Commission, as described later.

- Article III deals with long-term care facilities. Part 31 contains general provisions derived from Part 201 of the Public Health Code. Part 32 addresses **nursing homes** and is derived from Part 217 of the PHC. Part 33 covers **homes for the aged** and is derived from Part 213 of the PHC. Part 34 deals with **hospices** and is derived from Part 214 of the PHC. Part 35 covers **adult foster care facilities** and is derived from the current Adult Foster Care Facility Licensing Act.

- Article V is concerned with **occupations**. Part 51 contains general provisions derived from part 161 of the Public Health Code. Part 54 addresses **nursing home administrators**, incorporating provisions from Part 173 of the PHC

- Part 173 (nursing home administrators), 213 (homes for the aged), 214 (hospices), and 217 (nursing homes) of the Public Health Code cited above, as well as the entire Adult Foster Care Facility Licensing Act, **would be repealed**. Parts 20173 (criminal history checks of employees) and 20178 (Alzheimer Disease services) of the PHC would also be repealed. Provisions from the repealed portions of the Public Health

Code would be incorporated as described above into the new Long-Term Health Care Continuum Act.

Long Term Care Commission

Membership. The bill would create a 30- member Long-Term Care Commission, which would be intended to reflect the geographic and cultural diversity of the state. The commission would contain 25 voting members appointed by the governor. Among the voting members would be 14 consumers, including seven "primary" consumers (some of whom would have to be users of Medicaid services), with the remainder being "secondary" consumers and representatives of consumer organizations. "Primary consumers" are actual users of long-term care services. "Secondary consumers" are family members and unpaid caregivers of consumers. "Consumers" are defined as individuals seeking or receiving public assistance for long-term care.

Other members to be appointed by the governor include seven providers of long-term health care or representatives of provider organizations; three direct care workers; and one individual from a state university with expertise in LTC research.

The commission would contain the following five non-voting ex-officio members: the state LTC ombudsman; the directors of the departments of Community Health, Human Services, and Labor and Economic Growth or their designated representatives; and a representative of the designated protection and advocacy system.

Voting members would serve for three-year terms or until a successor was appointed (although initial terms would be staggered). The commission would have to meet at least six times per year. A majority of voting members serving would constitute a quorum (as long as eight of those voting members were consumers). Commission members would be entitled to per diem compensation and to reimbursement of actual expense while acting as official representatives of the commission. Per diem compensation and the schedule of reimbursement expenses would be as established and appropriated annually by the legislature.

Commission Duties. The commission would be required to do all of the following:

--Serve as an effective and visible advocate of all consumers of long-term care supports and services.

--Participate in the preparation and review, prior to submission to the governor, of an ongoing, comprehensive statewide plan and budget for LTC services and support designs, allocations, and strategies to address and meet identified consumer preferences and needs.

--Ensure the broadest possible ongoing public participation in statewide planning.

--Ensure that broad, culturally competent, and effective public education initiatives are ongoing on LTC issues, choices, and opportunities for direct involvement by the public.

--Advise the governor and the legislature regarding changes in federal and state programs, statutes, and policies.

--Establish additional advisory committees, councils, or workgroups as deemed helpful or necessary to pursue the commission's mission.

Task Forces and Advisory Committee. The commission could appoint task forces and advisory committees when it determined that it was appropriate to provide professional or technical expertise related to a department or commission function or appropriate to provide additional public participation in a department or commission function. The Department of Community Health could request the commission to establish a task force or advisory committee.

An advisory committee to the department or a task force would terminate two years after the date of its creation or renewal unless the commission recommended its continuance. Upon the recommendation of the commission, the department director could reappoint or request reappointment of an advisory committee or task force which otherwise would have been terminated under this subsection. (However, the termination subsection does not apply to advisory councils, commission, boards, task forces, or other advisory bodies not specifically designated as advisory committees.) The commission would review and advise the director on the need for each advisory council, commission, board, task force or body established in the department two years after the effective of this act and every other year thereafter.

MCL 333.12615 et al.

FISCAL IMPACT:

House Bill 5762 would recodify existing portions of the Public Health Code and the Adult Foster Care Licensing Act. It appears the only major change to existing law is the creation of a 30-member Long-Term Care Commission in Part 3 of the bill. The bill provides that the commission shall meet at least six times per year and that commission members are entitled to per diem compensation and reimbursement for actual and necessary expenses. These provisions would increase state costs imposed on the Department of Community Health. Total annual costs would likely be no more than $20,000 annually. Indirectly, the bill would also increase costs to both the Department of Community Health and Department of Human Services in terms of participation in Commission meetings and possible task forces. Information is not available to estimate these costs.

POSITIONS*:*

Department of Community Health supports the bills. (4-18-06)

Department of Human Services supports the bills. (4-18-06)

AARP supports the bills. (4-18-06)

Area Agency on Aging supports the bills. (4-18-06)

Advanced Insurance Marketers support the bills. (4-18-06)

Michigan Advocacy Project supports the bills. (4-18-06)

Michigan Campaign for Quality Care supports the bills. (4-18-06)

Michigan Protection and Advocacy supports the bills. (4-18-06)

Health Care Association of Michigan opposes the bills (4-18-06)

Michigan Association for Homes and Services for the Aging opposes the bills. (4-18-06)

Michigan Center for Assisted Living opposes the bills. (4-18-06)

Legislative Analyst: E. Best
Fiscal Analyst: Bob Schneider

■ This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.

This grid identifies each section in House Bill 5762 (H-2), the corresponding current statutory citation, a brief description of the section, and the changes from the bill as introduced. The following changes have been made throughout House Bill 5762 (H-2) and therefore, are not identified in the changes column:

- **The term "long-term care facility" is no longer used. Instead, the terms nursing home, hospice, etc. are used as appropriate.**
- **References to "state fire marshal" are changed to "bureau of fire services."**
- **Individuals in nursing homes and hospices are referred to as patients.**
- **Individuals in homes for the aged and adult foster care facilities are referred to as residents.)**

HB 5762 (H-2) – Sections	Corresponding Current Law	Brief Description	Changes from HB 5762 (as introduced)
Article I – General Provisions			
Part 1 – Short Title, General Definitions, Construction, and Administration			Includes "Construction" in the heading.
101, 103, 105, and 109	Sections 1101-1117, 1201, 1212, and 2233 (PHC)	These are the general provisions and are comprised of definitions and some general intent and authority provisions. The provisions in House Bill 5762 are modeled after Parts 11 and 12 in the Public Health Code. Section 2233 is the Department's general rule making authority provision.	Corrected reference to Part 3 within the definition of "Commission." Definitions of Department and Director are deleted and included under the respective Parts that address the facilities under the respective departments' jurisdiction. Definition of "long term care" changed to "long term care supports." Definitions added for "office," "office of services to the aging," and "task force." Section 109 rewritten so that (1) applies to the MDCH and (2) applies to the MDCH. Includes current statutory language on delayed promulgation of new rules. Language in (2) was Section 3121 in the bill as introduced.
111	333.1212 (PHC)	Members of predecessor agency; continuation in office.	Section 111 added (formerly Section 3123 in the bill as introduced) and applies to both MDCH and MDHS.

HB 5762 (H-2) – Sections	Corresponding Current Law	Brief Description	Changes from HB 5762 (as introduced)
3107	333.20155 (PHC)	Department visits to long-term care facilities.	Added a new (4) and renumbered the remaining subsections. Also, pulls in subsections (16) – (23) from section 20155, which deal with the creation of a clarification work group, meanings of citation terms, etc.
3109	333.20156 (PHC)	Enter premises of applicant or licensee, enforcement of rules; certificate of approval from State Fire Marshal Division.	No change.
3111	333.20162 (PHC)	License; issuance; nonrenewable temporary permit; provisional license; procedure for closing facility; order to licensee upon finding of noncompliance; notice, hearing, and status requirements.	No change.
3113	333.20164 (PHC)	Duration of license or certification; no transferability.	Inserting current statutory reference to CON citation.
3115	333.20165 (PHC)	Denying, limiting, suspending, or revoking license or certification.	Inserting current statutory reference to CON citation.
3117	333.20166 (PHC)	Notice of intent to deny, limit, suspend, or revoke license or certification; service; contents; hearing; record, transcript; determination; powers of department; judicial order to appear and give testimony; contempt; failure to show need for health facility or agency.	Inserting current statutory reference to CON citation.
3119	333.20168 (PHC)	Emergency order limiting, suspending, or revoking license; limiting reimbursements or payments; hearing; contents of order; order not suspended by hearing.	No change.
3125	333.20173 (PHC)	Prohibition/restrictions on employing individuals convicted of certain disqualifying crimes.	Uses term of "health facility" which is defined on page 41 of the draft.
3125a	333.20173a (PHC)	Appeals process for persons who have been disqualified from or denied employment by a long-term care facility based on a criminal history check.	Uses term of "health facility" which is defined on page 41 of the draft.

HB 5762 (H-2) – Sections	Corresponding Current Law	Brief Description	Changes from HB 5762 (as introduced)
3127	333.20175 (PHC)	Maintaining record for each patient; wrongfully altering or destroying records; noncompliance; fine; confidentiality; disclosure; report or notice of disciplinary action; information provided in report; nature and use of certain records, data, and knowledge.	Restructured section by moving language into a new (2) and adding current statutory language regarding public records. Also, adds current section 20175 (8).
3129	333.20176 (PHC)	Notice of violation; investigation of complaints; notice of proposed action; public record; appeal; reinvestigation.	No change.
3129a	333.20176a (PHC)	Health facility; prohibited conduct; violation; fine.	No change.
3131	333.20177 (PHC)	Action to restrain, enjoin, or prevent establishment, maintenance, or operation of health facility or agency.	No change.
3133	333.20178 (PHC)	Long-term care facility; description of services to patients or residents with Alzheimer's disease; contents; "represents to the public" defined.	No change.
3135	333.20180 (PHC)	Long-term care facility; person making or assisting in originating, investigating, or preparing report or complaint; immunity from civil or criminal liability; disclosure of identity.	No change.
3137	333.20192 (PHC)	Do-not-resuscitate order; execution not required.	No change.
	333.20194 (PHC)	Pamphlets; display.	Section 3139 has been removed from the bill. The last part of (3), pertaining to the requirement to display the pamphlet, has been placed in Part 32 – Sec. 3223. The other provisions of 333.20194 will remain in the PHC.
3141	333.20198 (PHC)	Long-term care facility; prohibited conduct; violation as misdemeanor; penalty.	Removed from draft. Language is included in 3263 (nursing homes) and 4341 (home for the aged).
3143	333.20199 (PHC)	Violations; penalties.	No change.

HB 5762 (H-2) – Sections	Corresponding Current Law	Brief Description	Changes from HB 5762 (as introduced)
3145	333.20201 (PHC)	Policy describing rights and responsibilities; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discrimination against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights.	No change.
3147	333.20202 (PHC)	Responsibilities of patient or resident.	No change.
3149	333.20203 (PHC)	Guidelines; immunity; other remedies at law neither expanded nor diminished.	No change.
3151	333.20211 (PHC)	Summary of activities; availability of list and current inspection reports.	No change.
Part 32 – Nursing Homes			
3201	333.21701 (PHC)	Meanings words and phrases; general definitions and principles of construction.	No change.
3202	333.21702 (PHC)	Definitions; D to P.	No change.
3203	333.21703 (PHC)	Definitions; P to W.	No change.
3207	333.21707 (PHC)	Prescribing course of medical treatment; limitations on authority.	No change.
3211	333.21711 (PHC)	Licensing required; prohibited terms or abbreviations; license for formal or informal nursing care services; exception.	No change.
3212	333.21712 (PHC)	Nome of nursing home; change in name; prohibited terms.	No change.
3213	333.21713 (PHC)	Owner, operator, and governing body of nursing home; responsibilities and duties generally.	No change.

HB 5762 (H-2) – Sections	Corresponding Current Law	Brief Description	Changes from HB 5762 (as introduced)
3215	333.21715 (PHC)	Programs of planned and continuing nursing and medical care required; nurses and physicians in charge; nature and scope of services.	No change.
3216	333.21716 (PHC)	Nursing home; influenza vaccination.	No change.
3217	333.21717 (PHC)	Individuals excluded from nursing home; exception; approval of area and program.	No change.
3218	333.21718 (PHC)	Conditions of skilled nursing facility certification and participation in title 19 program; exception; exemption.	No change.
3219	333.21719 (PHC)	Immediate access to acute care facilities.	No change.
3220	333.21720 (PHC)	Nursing home administrator.	No change.
3220a	333.21720a (PHC)	Director of nursing; nursing personnel; natural disaster or other emergency.	No change.
3220b	333.21720b (PHC)	Agreement with county community mental health program.	No change.
3221	333.21721 (PHC)	Bond required.	No change.
3223	333.20194 & 333.21723 (PHC)	Individual responsible for receiving complaints and conducting investigations; posting information in nursing home; communication procedure; information posted on internet website; nursing home receiving Medicaid reimbursement.	Language from the last part of Sec. 3139 (3) in the bill as introduced, pertaining to the requirement to display pamphlets and make available complaint forms under Sec. 20194 of the PHC, has been placed in this section.
3231	333.21731 (PHC)	Licensee considered consumer of tangible personal property.	No change.
3233	333.21733 (PHC)	Smoking policy.	No change.
3234	333.21734 (PHC)	Nursing home; bed rails; provisions; guidelines; liability.	No change.

HB 5762 (H-2) – Sections	Corresponding Current Law	Brief Description	Changes from HB 5762 (as introduced)
3235	333.21735 (PHC)	Requirement of emergency generator system in nursing home.	No change.
3241	333.21741 (PHC)	Rules.	No change.
3243	333.21743 (PHC)	Disclosures; public inspection.	No change.
3244	333.21744 (PHC)	Professional advice and consultation.	No change.
3251	333.21751 (PHC)	Emergency petition to place nursing home under control of receiver; appointment of receiver; use of income and assets; major structural alteration; consultation; termination of receivership; accounting; disposition of surplus funds.	No change.
3255	333.21755 (PHC)	Grounds for refusal to issue license.	No change.
3257	333.21757 (PHC)	Provisional license.	No change.
3261	333.21761 (PHC)	Certification of nondiscrimination; violation of rights; giving preference to members of religious or fraternal institution or organization.	No change.
3263	333.21763 (PHC)	Access to nursing home patients; purposes; requirements; termination of visit; confidentiality; complaint; determination; prohibited entry.	No change.
3264	333.21764 (PHC)	Approval or disapproval of nonprofit corporation rendering assistance without charge; appeal; decision.	No change.
3265	333.21765 (PHC)	Policies and procedures; copy of rights enumerated in § 333.20201; reading or explaining rights; staff observance of rights, policies, and procedures.	Deletes reference to "mentally retarded individual" and replaces with "individual with mental retardation" in order to be consistent with the "individuals first" language used in the Mental Health Code.
3265a	333.21765a (PHC)	Certain admission conditions prohibited; enforcement of contract provisions or agreements in conflict with subsections (1) and (2).	No change.

HB 5762 (H-2) – Sections	Corresponding Current Law	Brief Description	Changes from HB 5762 (as introduced)
3266	333.21766 (PHC)	Written contract.	No change.
3267	333.21767 (PHC)	Guardian, trustee, conservator, patient's representative, or protective payee for patient; receipt for money or property of patient; statement of funds.	No change.
3271	333.21771 (PHC)	Abusing, mistreating, or neglecting patient; reports; investigation; retaliation prohibited.	No change.
3272	333.21772(PHC)	Interference with right to bring action or file complaint prohibited; retaliation prohibited.	No change.
3273	333.21773 (PHC)	Involuntary transfer or discharge of patient; notice; form; request for hearing; copy of notice; commencement of notice period; nonpayment; redemption; explanation and discussion; counseling services; prohibition; notice of nonparticipation in state plan for Medicaid funding.	No change.
3274	333.21774 (PHC)	Involuntary transfer or discharge; request for hearing; informal hearing; decision; burden of proof; procedures; time for leaving facility.	No change.
3275	333.21775 (PHC)	Continuation of Medicaid funding during appeal, transfer, or discharge period.	No change.
3276	333.21776 (PHC)	Transfer or discharge of patient; plan; counseling services.	No change.
3277	333.21777 (PHC)	Holding bed open during temporary absence of patient; option; title 19 patients.	No change.
3281	333.21781 (PHC)	Posting of license and other information.	No change.
3282	333.21782 (PHC)	Retention of documents for public inspection.	No change.
3284	333.21784 (PHC)	Threatening medical condition; notice; emergency treatment; comfort of patient.	No change.

HB 5762 (H-2) – Sections	Corresponding Current Law	Brief Description	Changes from HB 5762 (as introduced)
3285	333.21785 (PHC)	Discontinuance of operation; notice; relocation of patients.	No change.
3286	333.21786 (PHC)	Emergency closing of nursing home.	No change.
3287	333.21787 (PHC)	Michigan public health institute; consultation and contracts.	No change.
3291	333.21791 (PHC)	Advertising; false or misleading information prohibited.	No change.
3292	333.21792 (PHC)	Commission, bonus, fee, or gratuity; violation; penalty.	No change.
3295	333.21795 (PHC)	Education and training for unlicensed nursing personnel; criteria; competency examinations; rules.	No change.
3296	333.21796 (PHC)	Insuring proper licensing of licensed personnel.	No change.
3299a	333.21799a (PHC)	Nursing home; violation; complaint; investigation; disclosure; determination; listing violation and provisions violated; copies of documents; public inspection; report of violation; penalty; request for hearing; notice of hearing; "priority complaint" defined.	No change.
3299b	333.21799b (PHC)	Noncompliance; notice of finding; correction notices; hearing; verification of compliance; investigation; action; definitions; annual report; presumption.	No change.
3299c	333.21799c (PHC)	Violations; penalties; computation of civil penalties; paying or reimbursing patient; rules for quality of care allowance formula.	No change.
3299d	333.21799d (PHC)	Collection of civil penalty; noncompliance; order.	No change.
3299e	333.21799e (PHC)	Penalties and remedies cumulative.	No change.
			Entire **Part 33** – Homes for the Aged moved to the new **Part 43** under the new Article IV.

HB 5762 (H-2) – Sections	Corresponding Current Law	Brief Description	Changes from HB 5762 (as introduced)
Part 34 - Hospices			
3401	333.21401 (PHC)	Definitions; principles of construction.	No change.
3411	333.21411 (PHC)	License for hospice or hospice residence required; exception; use of term "hospice"; representation as hospice residence; exemption from licensure; separate license for health facility or agency; activities of health facility or agency not restricted; inspections and concurrent issuance of licenses.	No change.
3413	333.21413 (PHC)	Duties of owner, operator, and governing body of hospice or hospice residence.	No change.
3415	333.21415 (PHC)	Program of planned and continuous hospice care; direction of medical components; coordination, design, and provision of hospice services.	No change.
3417	333.21417 (PHC)	Disease or condition with terminal prognosis as prerequisite for admission to or retention for care.	No change.
3419	333.21419 (PHC)	Rules.	No change.
3420	333.21420 (PHC)	Exemption of hospices from license fees and certificate of need fees; period.	Removed this section because the PHC provision is out-dated and this language is no longer necessary.
			Entire **Part 35** – Adult Foster Care moved to the new **Part 45** under the new Article IV.
Article IV – Department of Human Services Facilities			New Article.
Part 41 – General Provisions			New Part.
4101		Definitions.	
4125	333.20173 (PHC)	Prohibition/restrictions on employing individuals convicted of certain disqualifying crimes.	Formerly under 3125 and 3534.

HB 5762 (H-2) – Sections	Corresponding Current Law	Brief Description	Changes from HB 5762 (as introduced)
4125a	333.20173a (PHC)	Appeals process for persons who have been disqualified from or denied employment by a long-term care facility based on a criminal history check.	Formerly under 3125a and 3534a.
Part 43 – Homes for the Aged			New Part added; formerly Part 33 in the original bill.
4301	Various (PHC)	Definitions.	Formerly under 3101 and 3301.
4303	333.20131 (PHC)	Establish a comprehensive system of licensure and certification; certification of health facility or agency; coordination, cooperation, and agreements; public disclosure. Licensure of health facility or agency; eligibility to participate in federal or state health program; personnel; services; and equipment; evidence of compliance; providing data and statistics.	Formerly under 3103. Subsection (6) is deleted.
4304	333.20151 (PHC)	Cooperation; professional advice and consultation.	Formerly under 3104.
4305	333.20142 (PHC)	Applications for licensure and certification; form; certifying accuracy of information; disclosures; reports; and notices; violation; penalty; false statement as felony.	Formerly under 3105.
4306		Certification of compliance with state and federal laws.	Formerly under 3106.
4307	333.20155 (PHC)	Department visits to long-term care facilities.	Formerly under 3107.
4309	333.20156 (PHC)	Enter premises of applicant or licensee, enforcement of rules; certificate of approval from State Fire Marshal Division.	Formerly under 3109.
4311	333.20162 (PHC)	License; issuance; nonrenewable temporary permit; provisional license; procedure for closing facility; order to licensee upon finding of noncompliance; notice, hearing, and status requirements.	Formerly under 3111.
4313	333.20164 (PHC)	Duration of license or certification; no transferability.	Formerly under 3113.

HB 5762 (H-2) – Sections	Corresponding Current Law	Brief Description	Changes from HB 5762 (as introduced)
4315	333.20165 (PHC)	Denying, limiting, suspending, or revoking license or certification.	Formerly under 3115.
4317	333.20166 (PHC)	Notice of intent to deny, limit, suspend, or revoke license or certification; service; contents; hearing; record, transcript; determination; powers of department; judicial order to appear and give testimony; contempt; failure to show need for health facility or agency.	Formerly under 3117.
4319	333.20168 (PHC)	Emergency order limiting, suspending, or revoking license; limiting reimbursements or payments; hearing; contents of order; order not suspended by hearing.	Formerly under 3119.
4327	333.20175 (PHC)	Maintaining record for each patient; wrongfully altering or destroying records; noncompliance; fine; confidentiality; disclosure; report or notice of disciplinary action; information provided in report; nature and use of certain records, data, and knowledge.	Formerly under 3127.
4329	333.20176 (PHC)	Notice of violation; investigation of complaints; notice of proposed action; public record; appeal; reinvestigation.	Formerly under 3129.
4329a	333.20176a (PHC)	Health facility; prohibited conduct; violation; fine.	Formerly under 3129a. Subsection (1) (b) deleted.
4331	333.20177 (PHC)	Action to restrain, enjoin, or prevent establishment, maintenance, or operation of health facility or agency.	Formerly under 3131.
4333	333.20178 (PHC)	Description of services to patients or residents with Alzheimer's disease; contents; "represents to the public" defined.	Formerly under 3133.
4335	333.20180 (PHC)	Person making or assisting in originating, investigating, or preparing report or complaint; immunity from civil or criminal liability; disclosure of identity.	Formerly under 3135.
4337	333.20192 (PHC)	Do-not-resuscitate order; execution not required.	Formerly under 3137.

HB 5762 (H-2) – Sections	Corresponding Current Law	Brief Description	Changes from HB 5762 (as introduced)
4341	333.20198 (PHC)	Long-term care facility; prohibited conduct; violation as misdemeanor; penalty.	Formerly under 3141.
4343	333.20199 (PHC)	Violations; penalties.	Formerly under 3143.
4345	333.20201 (PHC)	Policy describing rights and responsibilities; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discrimination against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights.	Formerly under 3145.
4347	333.20202 (PHC)	Responsibilities of patient or resident.	Formerly under 3147.
4349	333.20203 (PHC)	Guidelines; immunity; other remedies at law neither expanded nor diminished.	Formerly under 3149.
4351	333.20211 (PHC)	Summary of activities; availability of list and current inspection reports.	Formerly under 3151.
4367	333.21307 (PHC)	Exemptions.	Formerly, 3307 – no change.
4371	333.21311 (PHC)	License required; use of "home for aged" or similar term or abbreviation; minimum age for admission; waiver of age limitation; documentation; determination by director.	Formerly, 3311 – no change.
4373	333.21313 (PHC)	Owner, operator, and governing body of home for aged; responsibilities and duties generally.	Formerly, 3313 – no change.
4381	333.21321 (PHC)	Bond required.	Formerly, 3321 – no change.
4385	333.21325 (PHC)	Removal of resident from home for the aged; conditions.	Formerly, 3325 – no change.
4391	333.21331 (PHC)	Licensee considered consumer of tangible personal property.	Formerly, 3331 – no change.

HB 5762 (H-2) – Sections	Corresponding Current Law	Brief Description	Changes from HB 5762 (as introduced)
4392	333.21332 (PHC)	Home for the aged; influenza vaccination.	Formerly, 3332 – no change.
4393	333.21333 (PHC)	Smoking policy.	Formerly, 3333 – no change.
4395	333.21335	Requirement of emergency generator system in home for the aged.	New section. Should have been included in the bill as introduced.
Part 45 – Adult Foster Care Facilities			New Part added; formerly Part 35 in the original bill.
4501	400.702	Meanings of words and phrases.	Formerly, 3501 - no change.
4503	400.703	Definitions; A.	Formerly 3503 - no change.
4504	400.704	Definitions; C to F.	Formerly 3504 - no change.
4505	400.705	Definitions; G to N.	Formerly 3505 - no change.
4506	400.706	Definitions; P to Q.	Formerly 3506 -no change.
4507	400.707	Definitions; R to T.	Formerly 3507 - no change.
4508	400.708	Adult foster care licensing advisory council; creation; appointment, qualifications, and terms of members; vacancy; compensation; schedule for reimbursement; content and enforcement of rules; conducting business at public meeting; availability of writings to public.	Formerly 3508 - no change.
4509	400.709	Administration of act; reports, procedures, inspections, and investigations; advice and technical assistance; consultations; cooperation with other agencies; education of public.	Formerly 3509 - no change.
4510	400.710	Rules; variance, modification, or change; purposes; restriction; review.	Formerly 3510. Includes correct reference to DHS instead of DCH.
4511	400.711	Inspections; visitations; administration and enforcement of rules; reports; final determination as to license; public inspection of reports.	Formerly 3511. Includes correct reference to DHS instead of DCH and Department of Mental Health.

HB 5762 (H-2) – Sections	Corresponding Current Law	Brief Description	Changes from HB 5762 (as introduced)
			Removes reference to DLEG in (2). Removes language in (5) that requires DCH to provide an inspection report and certification as this is not done by DCH.
4512	400.712	Keeping and maintaining records and reports; examination and copying of books, records, and reports; confidentiality; inspection of records by resident.	Formerly 3512 - no change.
4513	400.713	License required; application; form; investigation; on-site evaluation; issuance or renewal of license; disclosures; maximum number of persons; stating type of specialized program; issuance of license to specific person at specific location; transferability of license; sale of facility; notice; items of noncompliance; refusal by department to issue or renew license; conditions; unlicensed facility; violation as misdemeanor; penalty; receipt of completed application; issuance of license within certain time period; inspections; report; "completed application" defined.	Formerly 3513 - no change.
4513a	400.713a	Fees.	Formerly 3513a - no change.
4513b	None	License issued under the former Adult Foster Care Facility Licensing Act reverts to license under this Act until the license expires.	Formerly 3513b - no change.
4514	400.714	Temporary license; issuance of regular license or provisional license; refusal to issue license; temporary license nonrenewable; plan of correction.	Formerly 3514 - no change.
4515	400.715	Temporary license; adult foster care congregate facility.	Formerly 3515 - no change.
4516	400.716	Temporary license; prohibitions.	Removed (1) because a Michigan Court of Appeals decision enjoined the Department from requiring AFCs licensed for 6 adults or less to obtain any zoning approval, including any restrictions on concentration (per DHS).
4517	400.717	Provisional license.	Formerly 3517 - no change.

HB 5762 (H-2) – Sections	Corresponding Current Law	Brief Description	Changes from HB 5762 (as introduced)
4518	400.718	Special license; rules.	Formerly 3518 - no change.
4519	400.719	Regular license; issuance; validity; application for temporary license; subsection (4) applicable to previously licensed facilities.	Formerly 3519 - no change.
4520	400.720	Certificate of approval from state fire marshal division or state department of mental health; compliance; denial or certification with limitations; hearing.	Formerly 3520. Includes correct reference to DHS instead of DCH. Eliminates (2) because it is no longer needed – DHS does not do this.
4521	400.721	Facility licensed on March 27, 1980; compliance with fire safety standards; section inapplicable to installation of smoke and heat detection equipment.	No change.
4522	400.722	Denying, suspending, revoking, refusing to renew, or modifying license; grounds; notice; hearing; decision; protest; receiving or maintaining adults requiring foster care as felony; penalty; relocation services; emergency license.	Formerly 3522 - no change.
4523	400.723	Complaint; specifications; resolution of issues; notice; failure to resolve issues; hearing; decision; finality; issuance of license.	Formerly 3523 - no change.
4524	400.724	Request for investigation; providing substance of complaint; disclosures; determining violation; initiation of investigation; findings; written determination or status report; final report; additional copies of documents; reimbursement; informing licensee of findings; public inspection of written determination; hearing; appeal.	Formerly 3524 - no change.
4525	400.725	Appeal to circuit court.	Formerly 3525 - no change.
4526	400.726	Name or designation of facility.	Formerly 3526 - no change.

HB 5762 (H-2) – Sections	Corresponding Current Law	Brief Description	Changes from HB 5762 (as introduced)
4526a	400.726a	Resident enrolled in licensed hospice program; exception to continuous nursing care requirement for purposes of § 400.703(4); do-not-resuscitate order included in assessment plan; protection to resident.	Formerly 3526a - no change.
4526b	400.726b	Adult foster care; description of services to patients or residents with alzheimer's disease; contents; "represents to the public" defined.	Formerly 3526b - no change.
4527	400.727	Posting license, inspection report, and other documents; retention of materials for public inspection.	Formerly 3527 - no change.
4529	400.729	Providing foster care to person related to licensee or licensee's spouse.	Formerly 3529 - no change.
4530	400.730	Injunction.	Formerly 3530 - no change.
4531	400.731	Violation as misdemeanor; prohibited conduct.	Formerly 3531 - no change.
4531a	400.731a	Person sentenced to perform community service.	Formerly 3531a - no change.
4532	400.732	Notices required.	Formerly 3532 – eliminated (1) because DHS is enjoined from doing this.
4533	400.733	Local ordinances, regulations, or construction codes.	Formerly 3533 - no change.
4536	400.736	Concurrent license as foster family home or foster family group home; receiving additional minor children; definitions.	Formerly 3536 - no change.
4537	400.737	Concurrently licensing adult foster care small group home as child caring institution; receiving additional children under 18 years of age; limitation on combined licensed capacity; definition.	Formerly 3537 - no change.

HB 5762 (H-2) – Sections	Corresponding Current Law	Brief Description	Changes from HB 5762 (as introduced)
			Entire **Article V (Occupations)** removed from bill – provisions will remain under the PHC.
			Entire **Part 51** – General Provisions removed from bill.
	Part 161	Corresponds to Part 161 of the Public Health Code.	Removed from bill – provisions will remain under the PHC .
			Entire **Part 54** – Nursing Home Administrators removed from bill – provisions will remain under the PHC.
	Part 173	Corresponds to Part 173 of the Public Health Code	Sections 5401-5419 removed from bill – provisions will remain under the PHC.
Enacting Section 1.		Repeal	Repeals just the Adult Foster Care Facility Licensing Act. Public Health Code provisions that need to be repealed are done so in HB 5919.
Enacting Section 2.		Tie-Bar	Tie-bars HB 5762 to HB 5919 – PHC Companion Bill. HB 5919 is also tie-barred to HB 5762.

MEMORANDUM

Date: June 24, 2006

To: Marsha Moers

From: Michael Head

CC: Long-Term Care Services and Supports Advisory Commission

RE: 2005 Deficit Reduction Act grant opportunity

We anticipate that the Centers for Medicare and Medicaid Services will issue a solicitation for competitive grant proposals to conduct Money Follows the Person Demonstration projects. We expect the solicitation to be released mid- to late summer with a due date approximately eight weeks later. These demonstration projects will allow states to receive increased federal match for Medicaid services for persons transitioning from nursing facilities to community living. I provided a brief overview of the DRA and the demonstration projects at the May 22 Commission meeting.

The DRA's requirements for these demonstration projects include "…assurance that the project was developed and will be operated through a public input process." This requirement has implications for the Commission because of (1) the Commission's charge to serve in a consumer advocacy role and to ensure broad public input, and (2) the relevance of the solicitation to the Long Term Care Task Force recommendations related to Money Follows the Person principles and flexible funding. This solicitation provides an excellent opportunity for the Commission to work with the Office of LTC Supports and Services on the development of the project and to facilitate public input.

It may be that the solicitation could be released and require action during the Commission's July-August break between meetings. To prepare for that possibility, I recommend that the Commission make arrangements for engaging in the development process outside of its regular meeting schedule. We could work with the Executive Committee or a sub-committee and arrange special meetings, possibly with a public hearing on the issues. I hope that your June 26 meeting agenda allows for planning for this opportunity.

Our work on other CMS grants has benefited from involvement of the Consumer Task Force, so we look forward to working with the Commission as a partner in developing grant projects.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Centers for Medicaid and State Operations

SMDL: 06-012

JUN - 9 2006

Dear State Medicaid Director:

This is one of a series of letters that provides guidance on the implementation of the Deficit Reduction Act of 2005 (DRA) enacted on February 8, 2006. (Pub. L. No. 109-171). Section 6036 of the DRA, Improved Enforcement of Documentation Requirements, creates a new subsection 1903(x) of the Social Security Act (the Act) that requires individuals claiming U.S. citizenship to provide satisfactory documentary evidence of citizenship or nationality when initially applying for Medicaid or upon a recipient's first Medicaid redetermination on or after July 1, 2006.

Prior to enactment of this provision, in order for an individual to qualify for Medicaid, the applicant had to declare under penalty of perjury (under section 1137(d)(1)(A)) that he/she is a national or citizen of the United States, and, if not a citizen or national of the United States, that the individual is in a satisfactory immigration status. Individuals who declared they were citizens did not have to do anything else to support that claim, although some States did require documentary evidence of such a claim. However, the individuals who declared they were aliens in a satisfactory immigration status were required in every State to provide documentary evidence of that claim. The new provision under Section 6036 effectively requires that the State obtain satisfactory documentation of a declaration of citizenship. Self-attestation of citizenship and identity is no longer an acceptable practice. The provisions of section 6036 do not affect individuals who have declared they are aliens in a satisfactory immigration status. As with other Medicaid program requirements, States must implement an effective process for assuring compliance with documentation of citizenship in order to obtain Federal matching funds, and effective compliance will be part of Medicaid program integrity monitoring.

Section 6036 specifies certain forms of acceptable evidence of citizenship or nationality and identity that are effective July 1, 2006. We have marked documents listed in section 6036 with asterisks "***" in the charts that follow. The statute also provides the Secretary with authority to specify, by regulation, other documents that provide proof and a reliable means of documentation of United States citizenship or nationality and personal identity. CMS plans to publish regulations that would exercise this authority. CMS has included documents it is, at present, considering utilizing in its upcoming rulemaking in the charts that follow.

A. Establishing United States (U.S.) Citizenship and Identity

Note: State Medicaid Agency determinations of citizenship are not binding on other federal agencies for any other purposes.

To establish U.S. citizenship the document must show:
- A U.S. place of birth, or
- That the person is a U.S. citizen.

Note: Children born in the U.S. to foreign sovereigns or diplomatic officers are not U.S. citizens.

To establish identity a document must show:
- Evidence that provides identifying information that relates to the person named on the document.

B. Documents Establishing U.S. Citizenship and Identity

The following Charts list acceptable evidence of U.S. citizenship and/or identity. Charts 1-4 address citizenship and Charts 1 and 5 address identity. If an individual presents documents from Chart 1 no other information would be required. If an individual presents documents from Charts 2-4, then an identity document from Chart 5 must also be presented. Charts 1-4 establish a hierarchy of reliability of citizenship documents and the following instructions specify when a document of lesser reliability may be accepted by the State. The State would make the decision whether documents of a given level of reliability are available. See discussion of additional documents for use when a child is 16 years of age or younger.

1. Primary Documents to Establish Both U.S. Citizenship and Identity (See Chart 1)

Primary evidence of citizenship and identity is documentary evidence of the highest reliability that conclusively establishes that the person is a U.S. citizen. In general, obtain primary evidence of citizenship and identity before using secondary evidence. Accept any of the documents listed in this Chart as primary evidence of both U.S. citizenship and identity if the document meets the listed criteria and there is nothing indicating the person is not a U.S. citizen (e.g., lost U.S. citizenship).

Note: Persons born in American Samoa (including Swain's Island) are generally U.S. non-citizen nationals. References in this guidance to "citizens" should be read as references to non-citizen nationals with respect to these persons. There is no difference in terms of Medicaid eligibility.

Note: References to documents issued by the Department of Homeland Security (DHS) include documents issued by its predecessor, the Immigration and Naturalization Services (INS). On March 1, 2003, the former INS became part of DHS, and its naturalization function was assumed by U.S. Citizenship and Immigration Services (USCIS) within DHS. However, even documents issued after this date may bear INS legends.

Applicants or recipients born outside the U.S. who were not citizens at birth must submit a document listed under primary evidence of U.S. citizenship.

Chart 1

Primary Documents	Explanation
***U.S. passport	The Department of State issues this. A U.S. passport does not have to be currently valid to be accepted as evidence of U.S. citizenship, as long as it was originally issued without limitation. Note: Spouses and children were sometimes included on one passport through 1980. U.S. passports issued after 1980 show only one person. Consequently, the citizenship and identity of the included person can be established when one of these passports is presented. Exception: Do not accept any passport as evidence of U.S. citizenship when it was issued with a limitation. However, such a passport may be used as proof of identity.
***Certificate of Naturalization (N-550 or N-570)	Department of Homeland Security issues for naturalization.
***Certificate of Citizenship (N-560 or N-561)	Department of Homeland Security issues certificates of citizenship to individuals who derive citizenship through a parent.

2. Secondary Documents to Establish U.S. Citizenship (See Chart 2)

Secondary evidence of citizenship is documentary evidence of satisfactory reliability that is used when primary evidence of citizenship is not available. In addition, a second document establishing identity MUST also be presented as described in item 5, Evidence of Identity.

Available evidence is evidence that exists and can be obtained within your State's reasonable opportunity period. The reasonable opportunity period is discussed under the heading "Reasonable Opportunity".

Accept any of the documents listed in this Chart as secondary evidence of U.S. citizenship if the document meets the listed criteria and there is nothing indicating the person is not a U.S. citizen (e.g., lost U.S. citizenship).

Applicants or recipients born outside the U.S. must submit a document listed under primary evidence of U.S. citizenship.

Chart 2

Secondary Documents	Explanation
A U.S. public birth record showing birth in: • one of the 50 U.S. States; • District of Columbia; • American Samoa • Swain's Island *Puerto Rico (if born on or after January 13, 1941); • *Virgin Islands of the U.S. (on or after January 17, 1917); • *Northern Mariana Islands (after November 4, 1986 (NMI local time)); or • Guam (on or after April 10, 1899)	The birth record document may be issued by the State, Commonwealth, territory or local jurisdiction. It must have been issued before the person was 5 years of age. An amended birth record document that is amended after 5 years of age is considered fourth level evidence of citizenship. Note: If the document shows the individual was born in Puerto Rico, the Virgin Islands of the U.S., or the Northern Mariana Islands before these areas became part of the U.S., the individual may be a collectively naturalized citizen. Collective naturalization occurred on certain dates listed for each of the territories. *See additional requirements for Collective Naturalization.
***Certification of Report of Birth (DS-1350)	The Department of State issues a DS-1350 to U.S. citizens in the U.S. who were born outside the U.S. and acquired U.S. citizenship at birth, based on the information shown on the FS-240. When the birth was recorded as a Consular Report of Birth (FS-240), certified copies of the Certification of Report of Birth Abroad (DS-1350) can be issued by the Department of State in Washington, D.C. The DS-1350 contains the same information as that on the current version of Consular Report of Birth FS-240. The DS-1350 is not issued outside the U.S.
***Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240)	The Department of State consular office prepares and issues this. A Consular Report of Birth can be prepared only at an American consular office overseas while the child is under the age of 18. Children born outside the U.S. to U.S. military personnel usually have one of these.
***Certification of Birth Abroad (FS-545)	Before November 1, 1990, Department of State consulates also issued Form FS-545 along with the prior version of the FS-240. In 1990, U.S. consulates ceased to issue Form FS-545. Treat an FS-545 the same as the DS-1350.
***United States Citizen	INS issued the I-179 from 1960 until 1973. It revised the form and

Identification Card (I-197) or the prior version I-179 (Section 6036 referred to these documents in error as an I-97.)	renumbered it as Form I-197. INS issued the I-197 from 1973 until April 7, 1983. INS issued Form I-179 and I-197 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings. Although neither form is currently issued, either form that was previously issued is still valid.
American Indian Card (I-872)	DHS issues this card to identify a member of the Texas Band of Kickapoos living near the U.S./Mexican border. A classification code "KIC" and a statement on the back denote U.S. citizenship.
Northern Mariana Card (I-873)	The former Immigration and Naturalization Service (INS) issued the I-873 to a collectively naturalized citizen of the U.S. who was born in the NMI before November 4, 1986. The card is no longer issued, but those previously issued are still valid.
Final adoption decree	The adoption decree must show the child's name and U.S. place of birth. In situations where an adoption is not finalized **and** the State in which the child was born will **not** release a birth certificate prior to final adoption, a statement from a State approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.
Evidence of civil service employment by the U.S. government	The document must show employment by the U.S. government before June 1, 1976
Official Military record of service	The document must show a U.S. place of birth (for example a DD-214 or similar official document showing a U.S. place of birth)

3. Third Level Documents to Establish U.S. Citizenship (See Chart 3)

Third level evidence of U.S. citizenship is documentary evidence of satisfactory reliability that is used when neither primary nor secondary evidence of citizenship is available. Third level evidence may be used ONLY when primary evidence cannot be obtained within the State's reasonable opportunity period (see reasonable opportunity discussion below), secondary evidence does not exist or cannot be obtained, **and** the applicant or recipient alleges being born in the U.S. In addition, a second document establishing identity MUST be presented as described in item 5, Evidence of Identity.

Accept any of the documents listed in this Chart as third level evidence of U.S. citizenship if the document meets the listed criteria, the applicant alleges birth in the U.S., and there is nothing indicating the person is not a U.S. citizen (e.g., lost U.S. citizenship).

Third level evidence is generally a non-government document established for a reason other than to establish U.S. citizenship and showing a U.S. place of birth. The place of birth on the non-government document and the application must agree.

Chart 3

Third Level Documents	Explanation
Extract of hospital record on hospital letterhead established at the time of the person's birth and was created at least 5 years before the initial application date and indicates a U.S. place of birth	Do not accept a souvenir "birth certificate" issued by the hospital. Note: For children under 16 the document must have been created near the time of birth or 5 years before the date of application.
Life or health or other insurance record showing a U.S. place of birth and was created at least 5 years before the initial application date	Life or health insurance records may show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.

4. Fourth Level Documents to Establish U.S. Citizenship (See Chart 4)

Fourth level evidence of U.S. citizenship is documentary evidence of the lowest reliability. Fourth level evidence should ONLY be used in the rarest of circumstances. This level of evidence is used ONLY when primary evidence is not available, both secondary and third level evidence do not exist or cannot be obtained within the State's reasonable opportunity period, and the applicant alleges a U.S. place of birth. In addition, a second document establishing identity MUST be presented as described in item 5, Evidence of Identity. Available evidence is evidence that can be obtained within the State's reasonable opportunity period as discussed below.

Accept any of the documents listed in this Chart as fourth level evidence of U.S. citizenship if the document meets the listed criteria, the applicant alleges U.S. citizenship, and there is nothing indicating the person is not a U.S. citizen (e.g., lost U.S. citizenship). In addition, a second document establishing identity must be presented.

Fourth level evidence, as described below, consists of documents established for a reason other than to establish U.S. citizenship and showing a U.S. place of birth. The U.S. place of birth on the document and the application must agree. The written affidavit described in this Chart may be used only when the State is unable to secure evidence of citizenship listed in any other Chart.

Chart 4

Fourth Level Documents	Explanation
Federal or State census record showing U.S. citizenship or a U.S. place of birth (Generally for	The census record must also show the applicant's age. Note: Census records from 1900 through 1950 contain certain citizenship information. To secure this information the

persons born 1900 through 1950).	applicant, recipient or State should complete a Form BC-600, Application for Search of Census Records for Proof of Age. Add in the remarks portion "U.S. citizenship data requested." Also add that the purpose is for Medicaid eligibility. This form requires a fee.
Other document as listed in the explanation that was created at least 5 years before the application for Medicaid	This document must be one of the following and show a U.S. place of birth: • Seneca Indian tribal census record • Bureau of Indian Affairs tribal census records of the Navaho Indians • U.S. State Vital Statistics official notification of birth registration • An amended U.S. public birth record that is amended more than 5 years after the person's birth • Statement signed by the physician or midwife who was in attendance at the time of birth
Institutional admission papers from a nursing home, skilled nursing care facility or other institution and was created at least 5 years before the initial application date and indicates a U.S. place of birth	Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.
Medical (clinic, doctor, or hospital) record and was created at least 5 years before the initial application date and indicates a U.S. place of birth	Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. Note: An immunization record is not considered a medical record for purposes of establishing U.S. citizenship. Note: For children under 16 the document must have been created near the time of birth or 5 years before the date of application.
Written Affidavit	Affidavits should ONLY be used in rare circumstances. An affidavit by at least two individuals of whom one is not related to the applicant/recipient and who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship. The person(s) making the affidavit must be able to provide proof of his/her own citizenship and identity for the affidavit to be accepted. If the affiant has information which explains why documentary evidence establishing the applicant's claim of citizenship does not exist or cannot be readily obtained,

	the affidavit should contain this information as well. It must also be signed under penalty of perjury by the person making the affidavit. A second affidavit from the applicant/recipient or other knowledgeable individual explaining why documentary evidence does not exist or cannot be readily obtained must also be requested.

5. Evidence of Identity (See Chart 5)

Section 1903(x) provides that identity must be established. When primary evidence of citizenship described in number 1 above is not available, a document from the lists in number 2 through 4 may be presented if accompanied by an identity document from this list.

Chart 5

Documents to Establish Identity	**Explanation**
Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native tribal document.	Acceptable if the document carries a photograph of the applicant or recipient, or has other personal identifying information relating to the individual.
***Any identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act	Use 8 CFR 274a.2(b)(1)(v)(B)(1). This section includes the following acceptable documents for Medicaid purposes: • driver's license issued by State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight or eye color. • School identification card with a photograph of the individual • U.S. military card or draft record • Identification card issued by the Federal, State, or local government with the same information included on driver's licenses • Military dependent's identification card • Native American Tribal document • U.S. Coast Guard Merchant Mariner card Note: For children under 16, school records may include nursery or daycare records. If none of the above documents in the preceding charts are available, an affidavit may be used. An affidavit is only acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of the birth of the child and cannot be used if an affidavit for citizenship was provided.

	Exception: Do not accept a voter's registration card or Canadian driver's license as listed in 8 CFR 274a.2(b)(1)(v)(B)(1).

Collective Naturalization

The following will establish U.S. citizenship for collectively naturalized individuals:

Puerto Rico:

- Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's statement that he or she was residing in the U.S., a U.S. possession or Puerto Rico on January 13, 1941; or
- Evidence that the applicant was a Puerto Rican citizen and the applicant's statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain.

U.S. Virgin Islands:

- Evidence of birth in the U.S. Virgin Islands, and the applicant's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927;
- The applicant's statement indicating resident in the U.S. Virgin Islands as a Danish citizen on January 17, 1917 and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; or
- Evidence of birth in the U.S. Virgin Islands and the applicant's statement indicating residence in the U.S., a U.S. possession or territory or the Canal Zone on June 28, 1932.

Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)):

- Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. territory or possession on November 3, 1986 NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time);
- Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or
- Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time).

Note: If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

Treatment of Title IV-E Children and Individuals Receiving Services through Medicaid Section 1115 Demonstrations

Title IV-E children receiving Medicaid must have in their Medicaid file a declaration of citizenship or satisfactory immigration status and documentary evidence of the citizenship or satisfactory immigration status claimed on the declaration.

Individuals who are receiving benefits under a section 1115 demonstration project approved under Title XI authority are subject to this provision. This includes expansion eligible individuals under statewide section 1115 demonstrations and family planning demonstrations.

Driver's License Documentation to Establish Both Citizenship and Identification

Section 6036(a)(3)(B)(iv) of the DRA permits the use of a valid State-issued driver's license or other identity document described in Section 274A(b)(1)(D) of the Immigration and Nationality Act, but only if the State issuing the license or such document requires proof of United States citizenship before issuance of such license or document or obtains a social security number from the applicant and verifies before certification that such number is valid and assigned to the applicant who is a citizen. CMS is not currently aware that any State has these processes in place at this time. Therefore, until such time that a State has this requirement in place this documentation may not be accepted.

Effective Date

For new Medicaid applicants or for currently enrolled individuals, the State must obtain evidence of citizenship at the time of application or at the time of the first redetermination occurring on or after July 1, 2006. Recipients will need to provide such documentation only once unless doubt is cast on the situation because once citizenship is established it is a circumstance not likely to change.

Reasonable Opportunity

Beginning July 1, 2006 self attestation of citizenship by applicants or recipients will no longer be acceptable. Therefore, at the time of application or redetermination, the State must give an applicant or recipient, who has signed a declaration required by section 1137(d) of the Act and claims to be a citizen, a reasonable opportunity to present documents establishing U.S. citizenship or nationality and identity. For individuals who are already Medicaid recipients, such individuals remain eligible until determined ineligible as required by Federal regulations at 42 CFR 435.930. A determination terminating eligibility may be made only after the recipient has been given a reasonable opportunity to present evidence of citizenship or the State determines the individual has not made a good faith effort to present satisfactory documentary evidence of citizenship. By contrast, applicants for Medicaid (who are not currently receiving Medicaid), should not be made eligible until they have presented the required evidence. This is no different than current policy regarding information which an initial applicant must submit in order for the State to make an eligibility determination.

The "reasonable opportunity period" should be consistent with the State's administrative requirements such that the State does not exceed the time limits established in Federal regulations for timely determination of eligibility in 42 CFR 435.911. The regulations permit exceptions from the time limits when an applicant or recipient in good faith tries to present documentation, but is unable to do so because the documents are not available. In such cases, the State should assist the individual in securing evidence of citizenship. In these situations, States may use matches with other agencies to assist applicants or recipients to meet the requirements of the law. For example, States already receive the State Data Exchange (SDX). Therefore, a match of Medicaid applicants or recipients to the SDX that shows the individual has

proved citizenship would satisfy the documentation requirement of this provision with respect to SSI recipients. An SSI recipient's citizenship status can be found in the Alien Indicator Code at position 578 on the SDX. The BENDEX record is an extract of the Master Beneficiary Record and it does not currently house any data on U.S. citizenship or alien status; therefore, this system may not be utilized. States may use matches with State vital statistics agencies to assist applicants or recipients to document citizenship.

Applicants or Recipients Needing Assistance

If the applicant or recipient is homeless, an amnesia victim, mentally impaired, or physically incapacitated and lacks someone who can act for the individual, and cannot provide evidence of U.S. citizenship or identity, the State should assist the applicant or recipient to document U.S. citizenship and identity.

State Processes and Best Practices

- All documents must be either originals or copies certified by the issuing agency. Copies or notarized copies may not be accepted.
- States must maintain copies in the case record or data base and make available for compliance audits.
- States may permit applicants and recipients to submit such documentary evidence without appearing in person at a Medicaid office.
- If documents are determined to be inconsistent with pre-existing information, are counterfeit, or altered, States should investigate for potential fraud and abuse, including but not limited to, referral to the appropriate State and Federal law enforcement agencies and/or the agency that issued the document.
- Presentation of documentary evidence of citizenship is a one time activity; once a person's citizenship is documented and recorded in a State database subsequent changes in eligibility should not require repeating the documentation of citizenship unless later evidence raises a question of the person's citizenship. The State need only check its databases to verify that the individual already established citizenship.
- A number of States have long required their applicants to document citizenship. New York, New Hampshire, and Montana report that they have, as part of the Medicaid eligibility process, required documentation of citizenship for many years without undue hardship to either applicants or the State. New York and New Hampshire have published guidelines for documenting U.S. citizenship that generally mirror the list of acceptable documents contained in this letter. Any State that currently has a process in place to document citizenship should review this State Medicaid Director's letter and modify their process, as appropriate, to ensure conformity with Section 6036 of the Deficit Reduction Act of 2005.

Denial, Termination, Notice and Appeals

The enactment of section 6036 does not change any CMS policies regarding the taking and processing of applications for Medicaid except the new requirement for presentation of documentary evidence of citizenship. Thus, the requirement that determination of Medicaid eligibility be performed in a manner consistent with proper and efficient administration continues to apply. Likewise, the regulations at 42 CFR 435.902, 435.910(e), 435.912, 435.919 and 435.920 continue to apply when securing from applicants and recipients documentary evidence

of citizenship and identity. Thus, States are not obligated to make or keep eligible any individual who fails to cooperate with the requirement to present documentary evidence of citizenship and identity. Failure to provide this information is no different than the failure to provide any other information which is material to the eligibility determination.

An applicant or recipient who fails to cooperate with the State in presenting documentary evidence of citizenship may be denied or terminated. Failure to cooperate consists of failure by an applicant recipient or that individual's representative, after being notified, to take a required action. Notice and appeal rights and adequate and timely notice must be given to beneficiaries if the State denies or terminates an individual for failure to cooperate with the requirement to provide documentary evidence of citizenship. In the case of recipients, the notice must be in advance.

Federal Financial Participation (FFP) for Administrative Expenditures
CMS will provide FFP for State expenditures to carry out the provisions of section 1903(x) at the match rate for program administration.

Compliance
FFP will not be available if a State does not require applicants and recipients to provide satisfactory documentary evidence of citizenship, or does not secure such documentary evidence which includes the responsibility to accept only authentic documents on or after July 1, 2006. The Centers for Medicare & Medicaid Services (CMS) will review implementation of section 6036 to determine whether claims for FFP for services provided to citizens should be deferred or disallowed. Additionally, CMS will monitor the extent to which the State is using primary evidence to establish both citizenship and identity and will require corrective action to ensure the most reliable evidence is routinely being obtained.

CMS requires that as a check against fraud, using currently available automated capabilities, States will conduct a match of the applicant's name against the corresponding Social Security number that was provided. In addition, CMS, in cooperation with other agencies of the federal government, is establishing automated capabilities through which a State would be able to verify citizenship and identity of Medicaid applicants. When these capabilities become available, States will be required to match files for individuals who used third or fourth tier documents to verify citizenship and fifth level documents to verify identity , and CMS will make available to States necessary information in this regard in a future State Medicaid Director's Letter . States are hereby directed to ensure that all case records within this category will be so identified and made available to conduct these automated matches. CMS may also require States to match files for individuals who used first or second level documents to verify citizenship as well. CMS may provide further guidance to States with respect to actions required in a case of a negative match.

Outreach Plan
CMS will implement an outreach plan to explain the requirements of section 1903(x). In addition, we will place on our website tools States may use in conducting similar outreach. Meanwhile, we encourage States to alert your Medicaid beneficiaries and potential applicants as soon as possible about the requirement to provide acceptable documentary evidence of citizenship upon Medicaid application or upon initial redetermination and how the requirements

may be met. We encourage States to work with organizations and applicants in meeting this requirement. Also, we encourage States to begin reviewing files and procedures to determine what information is currently on hand to minimize the workload associated with this requirement beginning July 1, 2006. We are confident that your implementing procedures will assure compliance with this requirement.

Questions

Questions regarding this provision may be directed to Jean Sheil, Director, Family and Children's Health Programs Group at 7500 Security Blvd., Mail Stop S2-01-16, Baltimore, Maryland 21244-1850.

Sincerely,

Dennis G. Smith
Director

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
for Medicaid and State Operations

Martha Roherty
Director, Health Policy Unit
American Public Human Services Administration

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Jacalyn Bryan Garden
Director of Policy and Programs
Association of State and Territorial Health Officials

Christie Raniszewski Herrara
Director, Health and Human Services Task Force
American Legislative Exchange Council

Lynne Flynn
Director for Health Policy
Council of State Governments

Citizenship Documentation Provision of DRA

Conference Call Replay Available

On Monday, June 19th, Families USA held a conference call about the citizenship documentation provision of the Deficit Reduction Act of 2005. Nearly 400 people participated in the call. Because the high volume of calls, some people may not have been able to participate. Families USA apologizes for any inconvenience this may have caused. The good news is that the call was recorded, and a replay is available on Families USA's website for anyone who did not get a chance to participate or wants to listen again: http://ga3.org/ct/X7S1Iw51UmO3/

Fact Sheet on New Requirements

The Kaiser Commission on Medicaid and the Uninsured provided a two-page fact sheet on the new requirements for citizenship documentation in Medicaid. This fact sheet provides information on the new federal requirement that all U.S. citizens and nationals applying for or renewing their Medicaid coverage provide documentation of their citizenship status and examines the implications for Medicaid beneficiaries and the states.

The fact sheet is available at: http://www.kff.org/medicaid/7533.cfm

During discussion that followed the Deficit Reduction Act (DRA) of 2005 presentation at the May 22 meeting, Commissioner Turnham expressed concern over how new federal identity requirements may affect individuals who currently receive or make application for Medicaid benefits. The following information is provided to help you better understand the provisions of the law and implications it may have for the constituency you represent as a member of the LTC Supports and Services Advisory Commission.

Section 6036 of the DRA is intended to ensure that Medicaid beneficiaries are eligible for services without imposing undue burdens on them or the states. American citizenship or legal immigration status has always been a requirement for Medicaid eligibility, however beneficiaries could assert their status by checking a box on a form. Beginning July 1, 2006, the DRA passed by the U.S. Congress and signed by President Bush requires every state Medicaid program to see actual documentary evidence before eligibility is granted or renewed and services/payment begins.

The Centers for Medicare and Medicaid Services (CMS) has issued guidance to states that:
- allows a wide range of documents to be used, listed in four tiers of preference
- allows for affidavits to be filed in rare circumstances when all other attempts to obtain documentation fail
- requires states to provide reasonable opportunity for current beneficiaries to obtain documentation when eligibility is being re-determined
- informs states about the ability to do computer data matching with other systems
- announces plans to work with other federal agencies to develop automated capabilities for verifying citizenship that states will be required to use
- announces plans for an aggressive outreach campaign to educate states and interest groups on how to inform and assist beneficiaries with the new requirement

The State Medicaid Directors letter and a Medicaid Fact Sheet that provide guidance on the implementation of the DRA and can be accessed at the CMS website at: http://www.cms.hhs.gov/MedicaidEligibility/05_ProofofCitizenship.asp

Issues not yet resolved in the federal guidance are:
- allowing for presumptive eligibility while documents are being gathered
- establishing a hardship exception (a feature for other Medicaid eligibility criteria) for recipients/applicants who cannot meet the standards,
- allowing other kinds of documentation such as Medicare cards, religious records, etc.

A good source of continuing information about the DRA requirements can be found at www.familiesusa.org.

Additional discussion of will occur at a future Advisory Commission meeting.

Regards,

Marsha Moers, Chair

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 352-G
200 Independence Avenue, SW
Washington, DC 20201

Public Affairs Office

MEDICAID FACT SHEET

FOR IMMEDIATE RELEASE
Friday, June 9, 2006

Contact: CMS Public Affairs
(202) 690-6145

HHS ISSUES CITIZENSHIP GUIDELINES FOR MEDICAID ELIGIBIITY

Overview of New Guidance on Citizenship Documentation for Medicaid Benefits

HHS today issued guidelines for states to implement a new requirement, effective July 1, that persons applying for Medicaid document their citizenship. The new documentation requirement is outlined in Section 6036 of the Deficit Reduction Act of 2005 (DRA) and is intended to ensure that Medicaid beneficiaries are citizens without imposing undue burdens on them or the states.

Recognizing the diversity of beneficiaries served by Medicaid, the guidelines provide for a range of ways that citizenship status and personal identity may be documented. If other forms of documentation cannot be obtained, documentation may be provided by a written affidavit, signed under penalty of perjury, from two citizens, one of whom cannot be related to the applicant or recipient, who have specific knowledge of a beneficiary's citizenship status. Affidavits can only be used in rare circumstances. Additional types of documentation, such as school records, may be used for children. Current beneficiaries should not lose benefits during the period in which they are undertaking a good-faith effort to provide documentation to the state.

The guidance letter to state Medicaid directors reflects extensive input from experts and groups. CMS received input from such groups as the National Association of State Medicaid Directors, the National Association of Community Health Centers, the National Mental Health Association and the Tribal Technical Advisory Group to CMS.

Today's letter will be followed by federal regulations that will appear in the Federal Register.

American citizenship or legal immigration status has always been a requirement for Medicaid eligibility, however, beneficiaries could assert their status by checking a box on a form . The DRA requires actual documentary evidence before Medicaid eligibility is granted or renewed beginning July 1. The provision requires that a person provide both evidence of citizenship and identity. In many cases, a single document will be enough to establish both citizenship and

-More-

identity such as a passport. However, if secondary documentation is used, such as a birth certificate, the individual will also need evidence of their identity. Once citizenship has been proven, it need not be documented again with each eligibility renewal unless later evidence raises a question.

Guidance Details

Documentary Evidence

The law specifies certain forms of acceptable evidence of citizenship and identity, and provides for the use of additional forms of documentation as established by federal regulations, when appropriate. Today's guidance outlines acceptable additional forms of documentary evidence.

The guidance adopts a hierarchical approach already in use by other programs in which documentary evidence of citizenship and identity is sought first from a list of primary documents. If an applicant or recipient presents evidence from the listing of primary documentation, no other information would be required. When such evidence cannot be obtained, the state will look to the next tier of acceptable forms of evidence. *A state must first seek documents from the primary list before looking to the secondary or tertiary lists.*

In particular, the following forms of documentation may be accepted:

- Acceptable primary documentation for identification and citizenship:
  - A U.S. Passport.
  - A Certificate of Naturalization (DHS Forms N-550 or N-570).
  - A Certificate of U.S. Citizenship (DHS Forms N-560 or N-561).
- Acceptable secondary documentation to verify proof of citizenship (an identity document is also required):
  - A U.S. birth certificate.
  - A Certification of birth issued by the Department of State (Form DS-1350).
  - A Report of Birth Abroad of a U.S. Citizen (Form FS-240).
  - A Certification of Birth Abroad (FS-545).
  - A U.S. Citizen I.D. card (DHS Form I-197).
  - An American Indian Card issued by the Department of Homeland Security with the classification code "KIC". (Issued by DHS to identify U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border).
  - Final adoption decree
  - Evidence of civil service employment by the U.S. government before June 1976,
  - An official military record of service showing a U.S. place of birth
  - A Northern Mariana Identification Card. (Issued by the INS to a collectively naturalized citizen of the United States who was born in the Northern Mariana Islands before November 4, 1986.).

- Acceptable third level documentation to verify proof of citizenship:
  - Extract of U.S. hospital record of birth established at the time of the person's birth and was created at least 5 years before the initial application date and indicates a U.S. place of birth.
  - Life or health or other insurance record showing a U.S. place of birth and was created at least 5 years before the initial application date
- Acceptable fourth level documentation to verify proof of citizenship:
  - Federal or State census record showing U.S. citizenship or a U.S. place of birth.
  - Institutional admission papers from a nursing home, skilled nursing care facility or other institution and was created at least 5 years before the initial application date and indicates a U.S. place of birth.
  - Medical (clinic, doctor, or hospital) record and was created at least 5 years before the initial application date and indicates a U.S. place of birth unless the application is for a child under 5
  - Other document that was created at least five years before the application for Medicaid. These documents are Seneca Indian tribal census record, Bureau of Indian Affairs tribal census records of the Navaho Indians, U.S. StateVital Statistics official notification of birth registration, an amended U.S. public birth record that is amended more than 5 years after the person's birth or a statement signed by the physician or midwife who was in attendance at the time of birth.
  - Written affidavit.

- Written affidavits may be used only in rare circumstances when the state is unable to secure evidence of citizenship from another listing. The affidavits must be supplied by at least two individuals, one of whom is not related to the applicant or recipient. Each must attest to having personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship. The individuals making the affidavit must be able to prove their own citizenship and identity for the affidavit to be accepted. Those making affidavits will be subject to prosecution for perjury. If the persons claiming knowledge of another's citizenship has information which explains why documentary evidence establishing the applicant's claim of citizenship does not exist or cannot be readily obtained, the affidavit should contain this information as well. A second affidavit from the applicant/recipient or other knowledgeable individual explaining why documentary evidence does not exist or cannot be readily obtained must also be requested.

- Acceptable documentation to verify proof of identity:
  - A current state driver's license bearing the individual's picture or State identity document also with the individual's picture.
  - Certificate of Indian Blood, or other U.S. American Indian/Alaska Native tribal document.

- Any identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act.

- Children who are age 16 or younger may have their identity documented using other means, when the child does not have or cannot get any document on the preceding lists.

  - School identification card with a photograph.
  - Military dependent's identification card if it contains a photograph.
  - School record that shows date and place of birth and parent(s) name.
  - Clinic, doctor or hospital record showing date of birth.
  - Daycare or nursery school record showing date and place of birth.
  - Affidavit signed under penalty of perjury by a parent or guardian attesting to the child's identity.

Driver's License Documentation to Establish Both Citizenship and Identification

Section 6036(a)(3)(B)(iv) of the DRA permits the use of a valid state-issued driver's license or other identity document described in Section 274A(b)(1)(D) of the Immigration and Nationality Act, but only if the state issuing the license or such document requires proof of United States citizenship before issuance of such license or document or obtains a Social Security number from the applicant and verifies before certification that such number is valid and assigned to the applicant who is a citizen. CMS is not currently aware that any state has these processes in place at this time. Therefore, until such time that a state has this requirement in place this documentation may not be accepted.

Reasonable Opportunity

At the time of application or redetermination, the state must give an applicant or recipient a "reasonable opportunity" to present documents establishing U.S. citizenship or nationality and identity. The guidance advises:

- An individual who is already enrolled in Medicaid will remain eligible if he/she continuously shows a good faith effort to present satisfactory evidence of citizenship and identity.

- Applicants for Medicaid should not be made eligible until they have presented the required evidence.

- If the applicant or recipient tries in good faith to present satisfactory documentation, but is unable because the documents are not available, the state should assist the individual in securing these documents.

- If the applicant or recipient cannot obtain the necessary documents and needs assistance (i.e., is homeless, mentally impaired, or physically incapacitated), and lacks someone who can act on their behalf, then the state should assist the applicant or recipient to document U.S. citizenship and identity.

Compliance

As with other Medicaid program requirements, states must implement an effective process for assuring compliance with documentation of citizenship in order to obtain federal matching funds, and effective compliance will be part of Medicaid program integrity monitoring. In particular, audit processes will track the extent to which states rely on lower (third and fourth level) categories of documentation, and on affidavits, with the expectation that such categories would be used relatively infrequently and less over time, as state processes and beneficiary documentation improves.

States will receive the normal 50 percent match for administrative expenses related to implementation of the new law.

Outreach

The Centers for Medicare & Medicaid Services, the agency that oversees the Medicaid program, will launch an aggressive outreach program to educate states and interested groups about the new requirement. These outreach efforts include presentations to interested groups and tools that states may use to help applicants and recipients understand the requirement. The tools will include talking points, questions and answers, a sample press release, drop-in article and lists of acceptable documents. The agency will also work closely with states to help them reach out to their current Medicaid enrollees and the general public outlining the new rules. CMS will hold training sessions with state officials including regular telephone consultations during which the agency will provide whatever technical assistance the states request. CMS will also provide speakers at national conferences of interested groups such as tribal organizations and advocacy groups for minority communities.

For more information about the citizenship documentation requirement, go to:
http://www.cms.hhs.gov/MedicaidEligibility/05_ProofofCitizenship.asp#TopOfPage

###

From: Glenna Taylor
Date: 6/13/2006 9:55:04 PM
Subject: HHS Issues Citizenship Guidelines For Medicaid Eligibility

HHS Issues Citizenship Guidelines For Medicaid Eligibility

On Friday, the Department of Health and Human Services issued the following guidelines for complying with this new requirement under the DRA.

HHS issued guidelines for states to implement a new requirement, effective July 1, that persons applying for Medicaid document their citizenship. The new documentation requirement is mandated by Section 6036 of the Deficit Reduction Act of 2005 (DRA) and is intended to ensure that Medicaid beneficiaries are citizens without imposing undue burdens on them or the states. Today's guidance letter to state Medicaid officials will be followed by federal regulations that will appear in the Federal Register.

Recognizing the diversity of beneficiaries served by Medicaid, the guidelines provide for a range of ways that citizenship status and personal identity may be documented. If other forms of documentation cannot be obtained, documentation may be provided by a written affidavit, signed under penalty of perjury, from two citizens, one of whom cannot be related to the applicant or recipient, who have specific knowledge of a beneficiary's citizenship status. Affidavits can only be used in rare circumstances. Additional types of documentation, such as school records, may be used for children. Current beneficiaries should not lose benefits during the period in which they are undertaking a good-faith effort to provide documentation to the state.

American citizenship or legal immigration status has always been a requirement for Medicaid eligibility, however, beneficiaries could assert their citizenship status by checking a box on a form. The DRA requires actual documentary evidence before Medicaid eligibility is granted or renewed beginning July 1. The provision requires that a person provide both evidence of citizenship and identity. In many cases, a single document will be enough to establish both citizenship and identity such as a passport. However, if secondary documentation is used, such as a birth certificate, the individual will also need evidence of their identity. Once citizenship has been proven, it need not be documented again with each eligibility renewal unless later evidence raises a question.

[A copy of the State Medicaid Director letter and a Fact Sheet are attached on the AAPD website at www.aapd.com/News/deficit/060612cms.htm. or, go to the CMS website: www.cms.hhs.gov/MedicaidEligibility/05_ProofofCitizenship.asp]

Annetta V. Austin
Office of External Affairs
Public Relations
Centers for Medicare and Medicaid Services
200 Independence Avenue S.W.
Washington, DC 20201
Voice: 202-690-6002
Email: aaustin@cms.hhs.gov

MSHDA

Michigan State Housing Development Authority

MEMORANDUM

TO: Authority Board Members

FROM: Michael R. DeVos, Executive Director

DATE: April 26, 2006

SUBJECT: Continuing Care Retirement Communities Demonstration Program Parameters

It is recommended the Authority Board adopt the following parameters for the Continuing Care Retirement Communities (CCRC) Demonstration Program, a collaboration between the Authority and the Michigan Department of Community Health (DCH). The demonstration program will finance up to six multifamily projects of varying size located in different geographical areas in 2006 and 2007.

It is also recommended that the Executive Director be delegated the ability to implement changes to the demonstration program as necessary, reporting back to the Board on an informational basis.

Background

CCRCs are a model of senior living that provides a range of options for housing and services allowing seniors to age in place. These options include independent living, assisted living, and skilled nursing care on the same site. CCRCs are generally market rate.

The Authority has extensive experience financing both independent and congregate senior housing, achieving affordable options for lower income seniors. However, lower income seniors needing additional services, such as assisted living, do not currently have an affordable option, except to be placed in a nursing home. As a result, it is estimated that 9% of Michigan's nursing home population or 5,000 residents do not actually require nursing home services. The primary reason these residents are in a nursing home is because they have incomes insufficient to afford assisted living. Developing more affordable assisted living for lower income seniors would provide them with another option. Moreover, it would save the state money. It requires twice as much funding to house and service a person in a nursing home than in an assisted living facility.

The Authority is currently reviewing a sample proposal, which includes six townhouses for independent living, a 132 unit building for congregate care living, and a building that will have 50 units for assisted living and 20 units for memory care assisted living. Each housing option includes market rate and affordable units. MSHDA would finance the housing and DCH would fund the services.

Key Parameters

- Department of Community Health Funding
- Range of Housing and Service Options
- Authority Financing

Department of Community Health (DCH) Funding: DCH has **committed $6 million** in **PROJECT-BASED** Medicaid funding for services. Residents must meet Medicaid income eligibility and health screening criteria.

Range of Housing and Service Options: Proposals must have a range of housing and service options including independent living and/or congregate living, and some kind of acute care assisted living, for example memory care assisted living. Proposals may outline a relationship with a skilled nursing care on or near the site.

It is envisioned there will be different types of housing ranging from cottages to apartments (studio, one bedroom, two bedroom). Units will be carefully designed for future adaptation based on changes in demand. Depending on market demand, developments will consist of a mix of affordable and market rate units.

It is also envisioned that proposals could include a retrofit of a section (floor, wing) of an existing independent, congregate, or federal Section 202 development to provide assisted living.

Proposals should describe the use of technology that will help seniors be more self-sufficient and reduce the burden of caregivers.

Authority Financing: The Authority will provide financing through its tax-exempt and taxable direct lending programs along with federal HOME funds. Proposals submitted through the taxable program will compete for a 9% LIHTC allocation. Developments will be underwritten using the current parameters for these programs.

If the proposal is a retrofit, MSHDA will provide a HOME grant not to exceed $1 million to cover the cost of the rehabilitation.

Request for Proposals (RFP)

The Authority will issue an RFP by the end of April inviting developers to submit proposals that will be due by the end of August. In the interim, the Authority will conduct an information session at the Michigan Conference on Affordable Housing in June. Successful proposals will be selected in October.

MEMORANDUM

Date: June 26, 2006

To: Marsha Moers, Chairperson, Michigan Long-term Care Supports and Services Advisory Commission

CC: Long-Term Care Services and Supports Advisory Commission

From: Michael J. Head

RE: Request for Medicaid Infrastructure Grant Letter of Support

Michigan's Department of Community Health is submitting a Basic Competitive Medicaid Infrastructure Grant (MIG) for four years of funding. The proposal was developed in partnership with advocacy organizations and state agencies. The department is requesting a letter of support from the Michigan Long-term Care Supports and Advisory Commission. The budget request for the first year of the grant is $500,000 in federal funds. The budget for years two, three, and four will be minimally $500,000, but is expected to be adjusted higher annually based on anticipated increases in Freedom to Work/Medicaid Buy-in (FTW/MBI) participation. This grant will fund 3.5 full-time employees in the Office of LTC Supports and Services focused on removing barriers to employment and increasing competitive employment for person with disabilities in Michigan. The grant will also fund a position at Disability Network/Michigan (formerly MACIL) to support the MI JOB Coalition, a partner in the development and operations in MIG projects.

The 2007 Michigan MIG will achieve the following interrelated outcomes:

- Increase the number and earnings of Freedom to Work/Medicaid Buy-in (FTW/MBI) participants competitively employed to 1500 by December 31, 2007. The FTW/MBI allows workers with disabilities to maintain Medicaid health care coverage as a key to attaining and maintaining employment.
- Conduct unified outreach to increase the capacity and sustainability of statewide sources of information promoting competitive employment. This outreach will be marketed to employers, organizations, agencies, and individuals.
- Further implement, evaluate, and refine the FTW/MBI program. An inter-departmental work team will identify and resolve other barriers to employment for persons with disabilities.

These efforts all support competitive employment opportunities for people with disabilities. The major objectives of this competition are to develop a comprehensive employment system that:

- Maximizes employment for people with disabilities;
- Increases the state's labor force through the inclusion of people with disabilities;
- Protects and enhances workers healthcare, other benefits, and employment supports.

Please see the attached proposed letter of support for the consideration of the commission.

DRAFT

June 26, 2006

Ms. Janet Olszewski, Director
Michigan Department of Community Health
201 Townsend Street
Capital View Building – 7th Floor
Lansing, Michigan 48913

Dear Ms. Olszewski:

Michigan's Long-Term Care Supports and Services Advisory Commission strongly endorses the state's proposal for a Basic Medicaid Infrastructure Grant. The Commission was established by Governor Granholm through Executive Order 2005-14 issued to oversee the implementation of recommendations made by Michigan's Medicaid Long-Term Care Task Force. Its role is central to developing a responsive, customer-driven system of Long-Term Care supports and services. Primary and secondary consumers make up a majority of the seventeen-member Commission.

The Commission recognizes the significant role employment plays in promoting general health and continued independence. The Commission applauds the success of the current Medicaid Infrastructure Grant, in partnering with the Medical Services Administration, to amend the State Plan so that individuals with disabilities can use personal care services in the workplace. The Commission understands that many barriers remain for individuals with disabilities, and that the continued work of Michigan's MIG project is vital to engaging stakeholders, identifying barriers and resolving those barriers. This work has significant implications for the quality of life for many individuals receiving long-term care services.

Michigan is strongly committed to improving access, quality and sufficiency of long-term care supports and services. The Medicaid Infrastructure Grant will address an important aspect of the long-term care system.

Sincerely,

Marsha Moers
Chairperson

FOR IMMEDIATE RELEASE
June 5, 2006

Granholm Announces Four Long Term Care Demo Sites
Single Points Of Entry Awards Represent Significant Progress Toward Governor's Critical Long Term Care Recommendations

LANSING - Keeping true to her promise of improving the state's long term care system, Governor Jennifer M. Granholm today announced four groundbreaking awards worth $34.83 million for Long Term Care Single Point of Entry (SPE) demonstration sites in Michigan.

The establishment of long term care SPEs was a key recommendation presented to the Governor and the Legislature in the final report of the Medicaid Long Term Care Task Force, issued in June 2005.

"I am thrilled that numerous groups, individuals, and agencies have worked tirelessly to put forward strong proposals for establishing these demonstration projects for Single Points of Entry around the state," Granholm said. "It is only through their broad, collaborative efforts that Michigan residents can have a single entry point for information that permits individual consumer choices. These awards help move Michigan toward offering an improved system that supports dignified, person centered, and quality lifestyles when there is a need for long term care."

The four demonstration sites were selected after undergoing a three part broad-based review process that included representatives from community groups and agencies, health facilities, advocacy groups, and state agencies. The selected demonstration awards were made to the independently governed bodies as follows:

Detroit - Submitted by Detroit Area Agency on the Aging (AAA) **$13.1 million**
Southwest Michigan - Submitted by Region IV AAA **$7.18 million**
Upper Peninsula - Submitted by U.P. Commission for Area Progress **$5.4 million**
Western Michigan - Submitted by HHS Health Options and AAA of Western Michigan **$9.15 million**

In addition to these initial SPE awards, regional areas that could not be funded at this time will be provided SPE planning grants for independent collaborative efforts that bring all stakeholders in the region together for the purpose of submitting a proposal for a subsequent SPE request for proposals.

The twenty-seven month demonstration projects will be administered by the Department of Community Health (MDCH), said MDCH Director Janet Olszewski.

"Single Points of Entry will help ensure that families are not forced to navigate a complex maze of agencies or services when they may be in crisis, or at their most vulnerable, and in need of long term care supports," she said.

Currently, Michigan expenditures exceed $2 billion in public and private funds for the state's 1.2 million of the state's aging population, and an additional number of people with disabilities who need long term supports and services.

Michigan's initial investment in single points of entry will help ensure cost effectiveness by controlling the growth of high cost services, and by coordinating the delivery of high quality services that people want to use, Olszewski said.

Single Points of Entry address a lack of consolidated and independent sources of information, supports, and assistance for long term care needs for Michigan residents.

The demonstration projects will provide the opportunity to carefully evaluate SPE models, and to identify solid performance measures, as Michigan moves forward in implementing SPEs on a statewide basis. SPEs will operate based upon a basic principle of ensuring that individuals are provided with timely, unbiased and appropriate information to enable informed consumer choice in planning for, and utilizing, long term care services.

The selected sites for the demonstration projects encompass an estimated 47.5 percent of the state's current Long Term Care Medicaid population and incorporate 36 of the state's 83 counties.

The demonstration projects, which are subject to approval by the State Administrative Board, are designed to implement proposed models for a locally/regionally based statewide system of Single Points of Entry. The SPE demonstration sites are expected to begin implementing their work plan in July 2006. MDCH will immediately begin working with the four grantees to develop state contracts authorizing the start of the demonstration projects. Projects are expected to continue for period of 27 months, and will be monitored for progress on an ongoing basis.

Single Points of Entry will ensure that people seeking long term care information, services or supports have access to one primary contact point that provides assistance to individuals in planning for their long term care needs. The designated agency will function as an independent entity, and cannot be a provider of direct services to assure that there is no real, or perceived, conflict of interest in serving the needs of the consumer.

For more information about Michigan's continued long term care improvement efforts, please visit www.michigan.gov/ltc. The site also includes information regarding the state's Office of Long Term Care Support and Services, the LTC Supports and Services Advisory Commission, and the Michigan Medicaid Long Term Care Task Force.

SUBSTITUTE FOR

HOUSE BILL NO. 5389

A bill to amend 1939 PA 280, entitled

"The social welfare act,"

(MCL 400.1 to 400.119b) by adding section 109i.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

SEC. 109I. (1) THE DIRECTOR OF THE DEPARTMENT OF COMMUNITY HEALTH SHALL DESIGNATE AND MAINTAIN LOCALLY OR REGIONALLY BASED SINGLE POINT OF ENTRY AGENCIES FOR LONG-TERM CARE THAT SHALL SERVE AS VISIBLE AND EFFECTIVE ACCESS POINTS FOR INDIVIDUALS SEEKING LONG-TERM CARE AND THAT SHALL PROMOTE CONSUMER CHOICE AND QUALITY IN LONG-TERM CARE OPTIONS.

(2) THE DEPARTMENT OF COMMUNITY HEALTH SHALL MONITOR SINGLE POINT OF ENTRY AGENCIES FOR LONG-TERM CARE TO ASSURE, AT A MINIMUM, ALL OF THE FOLLOWING:

(A) THAT BIAS IN FUNCTIONAL AND FINANCIAL ELIGIBILITY

DETERMINATION OR ASSISTANCE AND THE PROMOTION OF SPECIFIC SERVICES TO THE DETRIMENT OF CONSUMER CHOICE AND CONTROL DOES NOT OCCUR.

(B) THAT CONSUMER ASSESSMENTS AND SUPPORT PLANS ARE COMPLETED IN A TIMELY, CONSISTENT, AND QUALITY MANNER THROUGH A PERSON-CENTERED PLANNING PROCESS AND ADHERE TO OTHER CRITERIA ESTABLISHED BY THIS SECTION AND THE DEPARTMENT OF COMMUNITY HEALTH.

(C) THE PROVISION OF QUALITY ASSISTANCE AND SUPPORTS.

(D) THAT QUALITY ASSISTANCE AND SUPPORTS ARE PROVIDED TO APPLICANTS AND CONSUMERS IN A MANNER CONSISTENT WITH THEIR CULTURAL NORMS, LANGUAGE OF PREFERENCE, AND MEANS OF COMMUNICATION.

(E) CONSUMER ACCESS TO AN INDEPENDENT CONSUMER ADVOCATE.

(F) THAT DATA AND OUTCOME MEASURES ARE BEING COLLECTED AND REPORTED AS REQUIRED UNDER THIS ACT AND BY CONTRACT.

(G) THAT CONSUMERS ARE ABLE TO CHOOSE THEIR SUPPORTS COORDINATOR.

(3) THE DEPARTMENT OF COMMUNITY HEALTH SHALL ESTABLISH AND PUBLICIZE A TOLL-FREE TELEPHONE NUMBER FOR AREAS OF THE STATE IN WHICH A SINGLE POINT OF ENTRY AGENCY IS OPERATIONAL AS A MEANS OF ACCESS.

(4) THE DEPARTMENT OF COMMUNITY HEALTH SHALL REQUIRE THAT SINGLE POINT OF ENTRY AGENCIES FOR LONG-TERM CARE PERFORM THE FOLLOWING DUTIES AND RESPONSIBILITIES:

(A) PROVIDE CONSUMERS AND ANY OTHERS WITH UNBIASED INFORMATION PROMOTING CONSUMER CHOICE FOR ALL LONG-TERM CARE OPTIONS, SERVICES, AND SUPPORTS.

(B) FACILITATE MOVEMENT BETWEEN SUPPORTS, SERVICES, AND SETTINGS IN A TIMELY MANNER THAT ASSURES CONSUMERS' INFORMED

CHOICE, HEALTH, AND WELFARE.

(C) ASSESS CONSUMERS' ELIGIBILITY FOR ALL MEDICAID LONG-TERM CARE PROGRAMS UTILIZING A COMPREHENSIVE LEVEL OF CARE ASSESSMENT APPROVED BY THE DEPARTMENT OF COMMUNITY HEALTH.

(D) ASSIST CONSUMERS IN OBTAINING A FINANCIAL DETERMINATION OF ELIGIBILITY FOR PUBLICLY FUNDED LONG-TERM CARE PROGRAMS.

(E) ASSIST CONSUMERS IN DEVELOPING THEIR LONG-TERM CARE SUPPORT PLANS THROUGH A PERSON-CENTERED PLANNING PROCESS.

(F) AUTHORIZE ACCESS TO MEDICAID PROGRAMS FOR WHICH THE CONSUMER IS ELIGIBLE AND THAT ARE IDENTIFIED IN THE CONSUMER'S LONG-TERM CARE SUPPORTS PLAN. THE SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM CARE SHALL NOT REFUSE TO AUTHORIZE ACCESS TO MEDICAID PROGRAMS FOR WHICH THE CONSUMER IS ELIGIBLE.

(G) UPON REQUEST OF A CONSUMER, HIS OR HER GUARDIAN, OR HIS OR HER AUTHORIZED REPRESENTATIVE, FACILITATE NEEDED TRANSITION SERVICES FOR CONSUMERS LIVING IN LONG-TERM CARE SETTINGS IF THOSE CONSUMERS ARE ELIGIBLE FOR THOSE SERVICES ACCORDING TO A POLICY BULLETIN APPROVED BY THE DEPARTMENT OF COMMUNITY HEALTH.

(H) WORK WITH DESIGNATED REPRESENTATIVES OF ACUTE AND PRIMARY CARE SETTINGS, FACILITY SETTINGS, AND COMMUNITY SETTINGS TO ASSURE THAT CONSUMERS IN THOSE SETTINGS ARE PRESENTED WITH INFORMATION REGARDING THE FULL ARRAY OF LONG-TERM CARE OPTIONS.

(I) REEVALUATE THE CONSUMER'S ELIGIBILITY AND NEED FOR LONG-TERM CARE SERVICES UPON REQUEST OF THE CONSUMER, HIS OR HER GUARDIAN, OR HIS OR HER AUTHORIZED REPRESENTATIVE OR ACCORDING TO THE CONSUMER'S LONG-TERM CARE SUPPORT PLAN.

(J) EXCEPT AS OTHERWISE PROVIDED IN SUBDIVISIONS (K) AND (*l*),

PROVIDE THE FOLLOWING SERVICES WITHIN THE PRESCRIBED TIME FRAMES:

(*i*) PERFORM AN INITIAL EVALUATION FOR LONG-TERM CARE WITHIN 2 BUSINESS DAYS AFTER CONTACT BY THE CONSUMER, HIS OR HER GUARDIAN, OR HIS OR HER AUTHORIZED REPRESENTATIVE.

(*ii*) DEVELOP A PRELIMINARY LONG-TERM CARE SUPPORT PLAN IN PARTNERSHIP WITH THE CONSUMER AND, IF APPLICABLE, HIS OR HER GUARDIAN OR AUTHORIZED REPRESENTATIVE WITHIN 2 BUSINESS DAYS AFTER THE CONSUMER IS FOUND TO BE ELIGIBLE FOR SERVICES.

(*iii*) COMPLETE A FINAL EVALUATION AND ASSESSMENT WITHIN 10 BUSINESS DAYS FROM INITIAL CONTACT WITH THE CONSUMER, HIS OR HER GUARDIAN, OR HIS OR HER AUTHORIZED REPRESENTATIVE.

(K) FOR A CONSUMER WHO IS IN AN URGENT OR EMERGENT SITUATION, WITHIN 24 HOURS AFTER CONTACT IS MADE BY THE CONSUMER, HIS OR HER GUARDIAN, OR HIS OR HER AUTHORIZED REPRESENTATIVE, PERFORM AN INITIAL EVALUATION AND DEVELOP A PRELIMINARY LONG-TERM CARE SUPPORT PLAN. THE PRELIMINARY LONG-TERM CARE SUPPORT PLAN SHALL BE DEVELOPED IN PARTNERSHIP WITH THE CONSUMER AND, IF APPLICABLE, HIS OR HER GUARDIAN OR AUTHORIZED REPRESENTATIVE.

(*l*) FOR A CONSUMER WHO RECEIVES NOTICE THAT WITHIN 72 HOURS HE OR SHE WILL BE DISCHARGED FROM A HOSPITAL, WITHIN 24 HOURS AFTER CONTACT IS MADE BY THE CONSUMER, HIS OR HER GUARDIAN, HIS OR HER AUTHORIZED REPRESENTATIVE, OR THE HOSPITAL DISCHARGE PLANNER, PERFORM AN INITIAL EVALUATION AND DEVELOP A PRELIMINARY LONG-TERM CARE SUPPORT PLAN. THE PRELIMINARY LONG-TERM CARE SUPPORT PLAN SHALL BE DEVELOPED IN PARTNERSHIP WITH THE CONSUMER AND, IF APPLICABLE, HIS OR HER GUARDIAN, HIS OR HER AUTHORIZED REPRESENTATIVE, OR THE HOSPITAL DISCHARGE PLANNER.

(M) INITIATE CONTACT WITH AND BE A RESOURCE TO HOSPITALS WITHIN THE AREA SERVICED BY THE SINGLE POINT OF ENTRY AGENCIES FOR LONG-TERM CARE.

(N) PROVIDE CONSUMERS WITH INFORMATION ON HOW TO CONTACT AN INDEPENDENT CONSUMER ADVOCATE AND A DESCRIPTION OF THE ADVOCATE'S MISSION. THIS INFORMATION SHALL BE PROVIDED IN A PUBLICATION PREPARED BY THE DEPARTMENT OF COMMUNITY HEALTH IN CONSULTATION WITH THESE ENTITIES. THIS INFORMATION SHALL ALSO BE POSTED IN THE OFFICE OF A SINGLE POINT OF ENTRY AGENCY.

(O) COLLECT AND REPORT DATA AND OUTCOME MEASURES AS REQUIRED BY THE DEPARTMENT OF COMMUNITY HEALTH, INCLUDING, BUT NOT LIMITED TO, THE FOLLOWING DATA:

(*i*) THE NUMBER OF REFERRALS BY LEVEL OF CARE SETTING.

(*ii*) THE NUMBER OF CASES IN WHICH THE CARE SETTING CHOSEN BY THE CONSUMER RESULTED IN COSTS EXCEEDING THE COSTS THAT WOULD HAVE BEEN INCURRED HAD THE CONSUMER CHOSEN TO RECEIVE CARE IN A NURSING HOME.

(*iii*) THE NUMBER OF CASES IN WHICH ADMISSION TO A LONG-TERM CARE FACILITY WAS DENIED AND THE REASONS FOR DENIAL.

(*iv*) THE NUMBER OF CASES IN WHICH A MEMORANDUM OF UNDERSTANDING WAS REQUIRED.

(*v*) THE RATES AND CAUSES OF HOSPITALIZATION.

(*vi*) THE RATES OF NURSING HOME ADMISSIONS.

(*vii*) THE NUMBER OF CONSUMERS TRANSITIONED OUT OF NURSING HOMES.

(*viii*) THE AVERAGE TIME FRAME FOR CASE MANAGEMENT REVIEW.

(*ix*) THE TOTAL NUMBER OF CONTACTS AND CONSUMERS SERVED.

(*x*) THE DATA NECESSARY FOR THE COMPLETION OF THE COST-BENEFIT ANALYSIS REQUIRED UNDER SUBSECTION (11).

(*xi*) THE NUMBER AND TYPES OF REFERRALS MADE.

(*xii*) THE NUMBER AND TYPES OF REFERRALS THAT WERE NOT ABLE TO BE MADE AND THE REASONS WHY THE REFERRALS WERE NOT COMPLETED, INCLUDING, BUT NOT LIMITED TO, CONSUMER CHOICE, SERVICES NOT AVAILABLE, CONSUMER FUNCTIONAL OR FINANCIAL INELIGIBILITY, AND FINANCIAL PROHIBITIONS.

(P) MAINTAIN CONSUMER CONTACT INFORMATION AND LONG-TERM CARE SUPPORT PLANS IN A CONFIDENTIAL AND SECURE MANNER.

(Q) PROVIDE CONSUMERS WITH A COPY OF THEIR PRELIMINARY AND FINAL LONG-TERM CARE SUPPORT PLANS AND ANY UPDATES TO THE LONG-TERM CARE PLANS.

(5) THE DEPARTMENT OF COMMUNITY HEALTH, IN CONSULTATION WITH THE OFFICE OF LONG-TERM CARE SUPPORTS AND SERVICES, THE MICHIGAN LONG-TERM CARE SUPPORTS AND SERVICES ADVISORY COMMISSION, THE DEPARTMENT, AND THE OFFICE OF SERVICES TO THE AGING, SHALL PROMULGATE RULES TO ESTABLISH CRITERIA FOR DESIGNATING LOCAL OR REGIONAL SINGLE POINT OF ENTRY AGENCIES FOR LONG-TERM CARE THAT MEET ALL OF THE FOLLOWING CRITERIA:

(A) THE DESIGNATED SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM CARE DOES NOT PROVIDE DIRECT OR CONTRACTED MEDICAID SERVICES. FOR THE PURPOSES OF THIS SECTION, THE SERVICES REQUIRED TO BE PROVIDED UNDER SUBSECTION (4) ARE NOT CONSIDERED MEDICAID SERVICES.

(B) THE DESIGNATED SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM CARE IS FREE FROM ALL LEGAL AND FINANCIAL CONFLICTS OF INTEREST WITH PROVIDERS OF MEDICAID SERVICES.

(C) THE DESIGNATED SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM CARE IS CAPABLE OF SERVING AS THE FOCAL POINT FOR ALL INDIVIDUALS, REGARDLESS OF AGE, SEEKING INFORMATION ABOUT LONG-TERM CARE IN THEIR REGION, INCLUDING INDIVIDUALS WHO WILL PAY PRIVATELY FOR SERVICES.

(D) THE DESIGNATED SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM CARE IS CAPABLE OF PERFORMING REQUIRED CONSUMER DATA COLLECTION, MANAGEMENT, AND REPORTING.

(E) THE DESIGNATED SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM CARE HAS QUALITY STANDARDS, IMPROVEMENT METHODS, AND PROCEDURES IN PLACE THAT MEASURE CONSUMER SATISFACTION AND MONITOR CONSUMER OUTCOMES.

(F) THE DESIGNATED SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM CARE HAS KNOWLEDGE OF THE FEDERAL AND STATE STATUTES AND REGULATIONS GOVERNING LONG-TERM CARE SETTINGS.

(G) THE DESIGNATED SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM CARE MAINTAINS AN INTERNAL AND EXTERNAL APPEAL PROCESS THAT PROVIDES FOR A REVIEW OF INDIVIDUAL DECISIONS.

(H) THE DESIGNATED SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM CARE IS CAPABLE OF DELIVERING SINGLE POINT OF ENTRY SERVICES IN A TIMELY MANNER ACCORDING TO STANDARDS ESTABLISHED BY THE DEPARTMENT OF COMMUNITY HEALTH AND AS PRESCRIBED IN SUBSECTION (4).

(6) A SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM CARE THAT FAILS TO MEET THE CRITERIA DESCRIBED IN THIS SECTION OR OTHER FISCAL AND PERFORMANCE STANDARDS PRESCRIBED BY CONTRACT AND SUBSECTION (7) OR THAT INTENTIONALLY AND KNOWINGLY PRESENTS BIASED INFORMATION THAT IS INTENDED TO STEER CONSUMER CHOICE TO PARTICULAR

LONG-TERM CARE SUPPORTS AND SERVICES IS SUBJECT TO DISCIPLINARY ACTION BY THE DEPARTMENT OF COMMUNITY HEALTH. DISCIPLINARY ACTION MAY INCLUDE, BUT IS NOT LIMITED TO, INCREASED MONITORING BY THE DEPARTMENT OF COMMUNITY HEALTH, ADDITIONAL REPORTING, TERMINATION AS A DESIGNATED SINGLE POINT OF ENTRY AGENCY BY THE DEPARTMENT OF COMMUNITY HEALTH, OR ANY OTHER ACTION AS PROVIDED IN THE CONTRACT FOR A SINGLE POINT OF ENTRY AGENCY.

(7) FISCAL AND PERFORMANCE STANDARDS FOR A SINGLE POINT OF ENTRY AGENCY INCLUDE, BUT ARE NOT LIMITED TO, ALL OF THE FOLLOWING:

(A) MAINTAINING ADMINISTRATIVE COSTS THAT ARE REASONABLE, AS DETERMINED BY THE DEPARTMENT OF COMMUNITY HEALTH, IN RELATION TO SPENDING PER CLIENT.

(B) IDENTIFYING SAVINGS IN THE ANNUAL STATE MEDICAID BUDGET OR LIMITS IN THE RATE OF GROWTH OF THE ANNUAL STATE MEDICAID BUDGET ATTRIBUTABLE TO PROVIDING SERVICES UNDER SUBSECTION (4) TO CONSUMERS IN NEED OF LONG-TERM CARE SERVICES AND SUPPORTS, TAKING INTO CONSIDERATION MEDICAID CASELOAD AND APPROPRIATIONS.

(C) CONSUMER SATISFACTION WITH SERVICES PROVIDED UNDER SUBSECTION (4).

(D) TIMELINESS OF DELIVERY OF SERVICES PROVIDED UNDER SUBSECTION (4).

(E) QUALITY, ACCESSIBILITY, AND AVAILABILITY OF SERVICES PROVIDED UNDER SUBSECTION (4).

(F) COMPLETING AND SUBMITTING REQUIRED REPORTING AND PAPERWORK.

(G) NUMBER OF CONSUMERS SERVED.

(H) NUMBER AND TYPE OF LONG-TERM CARE SERVICES AND SUPPORTS

REFERRALS MADE.

(I) NUMBER AND TYPE OF LONG-TERM CARE SERVICES AND SUPPORTS REFERRALS NOT COMPLETED, TAKING INTO CONSIDERATION THE REASONS WHY THE REFERRALS WERE NOT COMPLETED, INCLUDING, BUT NOT LIMITED TO, CONSUMER CHOICE, SERVICES NOT AVAILABLE, CONSUMER FUNCTIONAL OR FINANCIAL INELIGIBILITY, AND FINANCIAL PROHIBITIONS.

(8) THE DEPARTMENT OF COMMUNITY HEALTH SHALL DEVELOP STANDARD COST REPORTING METHODS AS A BASIS FOR CONDUCTING COST ANALYSES AND COMPARISONS ACROSS ALL PUBLICLY FUNDED LONG-TERM CARE SYSTEMS AND SHALL REQUIRE SINGLE POINT OF ENTRY AGENCIES TO UTILIZE THESE AND OTHER COMPATIBLE DATA COLLECTION AND REPORTING MECHANISMS.

(9) THE DEPARTMENT OF COMMUNITY HEALTH SHALL SOLICIT PROPOSALS FROM ENTITIES SEEKING DESIGNATION AS A SINGLE POINT OF ENTRY AGENCY AND, EXCEPT AS PROVIDED IN SUBSECTION (16), SHALL INITIALLY DESIGNATE NOT MORE THAN 4 AGENCIES TO SERVE AS A SINGLE POINT OF ENTRY AGENCY IN AT LEAST 4 SEPARATE AREAS OF THE STATE. THERE SHALL NOT BE MORE THAN 1 SINGLE POINT OF ENTRY AGENCY IN EACH DESIGNATED AREA. AN AGENCY DESIGNATED BY THE DEPARTMENT OF COMMUNITY HEALTH UNDER THIS SUBSECTION SHALL SERVE AS A SINGLE POINT OF ENTRY AGENCY FOR AN INITIAL PERIOD OF UP TO 3 YEARS, SUBJECT TO THE PROVISIONS OF SUBSECTION (6).

(10) THE DEPARTMENT OF COMMUNITY HEALTH SHALL EVALUATE THE PERFORMANCE OF SINGLE POINT OF ENTRY AGENCIES UNDER THIS SECTION ON AN ANNUAL BASIS.

(11) THE DEPARTMENT OF COMMUNITY HEALTH SHALL ENGAGE A QUALIFIED OBJECTIVE INDEPENDENT AGENCY TO CONDUCT A COST-BENEFIT ANALYSIS OF SINGLE POINT OF ENTRY, INCLUDING, BUT NOT LIMITED TO,

THE IMPACT ON MEDICAID LONG-TERM CARE COSTS.

(12) THE DEPARTMENT OF COMMUNITY HEALTH SHALL MAKE A SUMMARY OF THE ANNUAL EVALUATION, ANY REPORT OR RECOMMENDATION FOR IMPROVEMENT REGARDING THE SINGLE POINT OF ENTRY, AND THE COST-BENEFIT ANALYSIS AVAILABLE TO THE LEGISLATURE AND THE PUBLIC.

(13) NOT EARLIER THAN 12 MONTHS AFTER BUT NOT LATER THAN 24 MONTHS AFTER THE IMPLEMENTATION OF THE SINGLE POINT OF ENTRY AGENCY DESIGNATED UNDER SUBSECTION (9), THE DEPARTMENT OF COMMUNITY HEALTH SHALL SUBMIT A WRITTEN REPORT TO THE SENATE AND HOUSE OF REPRESENTATIVES STANDING COMMITTEES DEALING WITH LONG-TERM CARE ISSUES, THE CHAIRS OF THE SENATE AND HOUSE OF REPRESENTATIVES APPROPRIATIONS COMMITTEES, THE CHAIRS OF THE SENATE AND HOUSE OF REPRESENTATIVES APPROPRIATIONS SUBCOMMITTEES ON COMMUNITY HEALTH, AND THE SENATE AND HOUSE FISCAL AGENCIES REGARDING THE ARRAY OF SERVICES PROVIDED BY THE DESIGNATED SINGLE POINT OF ENTRY AGENCIES AND THE COST, EFFICIENCIES, AND EFFECTIVENESS OF SINGLE POINT OF ENTRY. IN THE REPORT REQUIRED UNDER THIS SUBSECTION, THE DEPARTMENT OF COMMUNITY HEALTH SHALL PROVIDE RECOMMENDATIONS REGARDING THE CONTINUATION, CHANGES, OR CANCELLATION OF SINGLE POINT OF ENTRY AGENCIES BASED ON DATA PROVIDED UNDER SUBSECTIONS (4) AND (10) TO (12).

(14) BEGINNING IN THE YEAR THE REPORT IS SUBMITTED AND ANNUALLY AFTER THAT, THE DEPARTMENT OF COMMUNITY HEALTH SHALL MAKE A PRESENTATION ON THE STATUS OF SINGLE POINT OF ENTRY AND ON THE SUMMARY INFORMATION AND RECOMMENDATIONS REQUIRED UNDER SUBSECTION (12) TO THE SENATE AND HOUSE OF REPRESENTATIVES APPROPRIATIONS SUBCOMMITTEES ON COMMUNITY HEALTH TO ENSURE THAT LEGISLATIVE REVIEW

OF SINGLE POINT OF ENTRY SHALL BE PART OF THE ANNUAL STATE BUDGET DEVELOPMENT PROCESS.

(15) THE DEPARTMENT OF COMMUNITY HEALTH SHALL PROMULGATE RULES TO IMPLEMENT THIS SECTION NOT LATER THAN 270 DAYS AFTER SUBMITTING THE REPORT REQUIRED IN SUBSECTION (13).

(16) THE DEPARTMENT OF COMMUNITY HEALTH SHALL NOT DESIGNATE MORE THAN THE INITIAL 4 AGENCIES DESIGNATED UNDER SUBSECTION (9) TO SERVE AS SINGLE POINT OF ENTRY AGENCIES OR AGENCIES SIMILAR TO SINGLE POINT OF ENTRY AGENCIES UNLESS ALL OF THE FOLLOWING OCCUR:

(A) THE WRITTEN REPORT IS SUBMITTED AS PROVIDED UNDER SUBSECTION (13).

(B) TWELVE MONTHS HAVE PASSED SINCE THE SUBMISSION OF THE WRITTEN REPORT REQUIRED UNDER SUBSECTION (13).

(C) THE LEGISLATURE APPROPRIATES FUNDS TO SUPPORT THE DESIGNATION OF ADDITIONAL SINGLE POINT OF ENTRY AGENCIES.

(17) A SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM CARE SHALL SERVE AS THE SOLE AGENCY WITHIN THE DESIGNATED SINGLE POINT OF ENTRY AREA TO ASSESS A CONSUMER'S ELIGIBILITY FOR MEDICAID LONG-TERM CARE PROGRAMS UTILIZING A COMPREHENSIVE LEVEL OF CARE ASSESSMENT APPROVED BY THE DEPARTMENT OF COMMUNITY HEALTH.

(18) ALTHOUGH A COMMUNITY MENTAL HEALTH SERVICES PROGRAM MAY SERVE AS A SINGLE POINT OF ENTRY AGENCY TO PROVIDE SERVICES TO INDIVIDUALS WITH MENTAL ILLNESS OR DEVELOPMENTAL DISABILITY, COMMUNITY MENTAL HEALTH SERVICES PROGRAMS ARE NOT SUBJECT TO THE PROVISIONS OF THIS ACT.

(19) FOR THE PURPOSES OF THIS SECTION:

(A) "ADMINISTRATIVE COSTS" MEANS THE COSTS THAT ARE USED TO

PAY FOR EMPLOYEE SALARIES NOT DIRECTLY RELATED TO CARE PLANNING AND SUPPORTS COORDINATION AND ADMINISTRATIVE EXPENSES NECESSARY TO OPERATE EACH SINGLE POINT OF ENTRY AGENCY.

(B) "ADMINISTRATIVE EXPENSES" MEANS THE COSTS ASSOCIATED WITH THE FOLLOWING GENERAL ADMINISTRATIVE FUNCTIONS:

(*i*) FINANCIAL MANAGEMENT, INCLUDING, BUT NOT LIMITED TO, ACCOUNTING, BUDGETING, AND AUDIT PREPARATION AND RESPONSE.

(*ii*) PERSONNEL MANAGEMENT AND PAYROLL ADMINISTRATION.

(*iii*) PURCHASE OF GOODS AND SERVICES REQUIRED FOR ADMINISTRATIVE ACTIVITIES OF THE SINGLE POINT OF ENTRY AGENCY, INCLUDING, BUT NOT LIMITED TO, THE FOLLOWING GOODS AND SERVICES:

(A) UTILITIES.

(B) OFFICE SUPPLIES AND EQUIPMENT.

(C) INFORMATION TECHNOLOGY.

(D) DATA REPORTING SYSTEMS.

(E) POSTAGE.

(F) MORTGAGE, RENT, LEASE, AND MAINTENANCE OF BUILDING AND OFFICE SPACE.

(G) TRAVEL COSTS NOT DIRECTLY RELATED TO CONSUMER SERVICES.

(H) ROUTINE LEGAL COSTS RELATED TO THE OPERATION OF THE SINGLE POINT OF ENTRY AGENCY.

(C) "AUTHORIZED REPRESENTATIVE" MEANS A PERSON EMPOWERED BY THE CONSUMER BY WRITTEN AUTHORIZATION TO ACT ON THE CONSUMER'S BEHALF TO WORK WITH THE SINGLE POINT OF ENTRY, IN ACCORDANCE WITH THIS ACT.

(D) "GUARDIAN" MEANS AN INDIVIDUAL WHO IS APPOINTED UNDER SECTION 5306 OF THE ESTATES AND PROTECTED INDIVIDUALS CODE, 1998 PA

386, MCL 700.5306. GUARDIAN INCLUDES AN INDIVIDUAL WHO IS APPOINTED AS THE GUARDIAN OF A MINOR UNDER SECTION 5202 OR 5204 OF THE ESTATES AND PROTECTED INDIVIDUALS CODE, 1998 PA 386, MCL 700.5202 AND 700.5204, OR WHO IS APPOINTED AS A GUARDIAN UNDER THE MENTAL HEALTH CODE, 1974 PA 258, MCL 300.1001 TO 300.2106.

(E) "INFORMED CHOICE" MEANS THAT THE CONSUMER IS PRESENTED WITH COMPLETE AND UNBIASED INFORMATION ON HIS OR HER LONG-TERM CARE OPTIONS, INCLUDING, BUT NOT LIMITED TO, THE BENEFITS, SHORTCOMINGS, AND POTENTIAL CONSEQUENCES OF THOSE OPTIONS, UPON WHICH HE OR SHE CAN BASE HIS OR HER DECISION.

(F) "PERSON-CENTERED PLANNING" MEANS A PROCESS FOR PLANNING AND SUPPORTING THE CONSUMER RECEIVING SERVICES THAT BUILDS ON THE INDIVIDUAL'S CAPACITY TO ENGAGE IN ACTIVITIES THAT PROMOTE COMMUNITY LIFE AND THAT HONORS THE CONSUMER'S PREFERENCES, CHOICES, AND ABILITIES. THE PERSON-CENTERED PLANNING PROCESS INVOLVES FAMILIES, FRIENDS, AND PROFESSIONALS AS THE CONSUMER DESIRES OR REQUIRES.

(G) "SINGLE POINT OF ENTRY" MEANS A PROGRAM FROM WHICH A CURRENT OR POTENTIAL LONG-TERM CARE CONSUMER CAN OBTAIN LONG-TERM CARE INFORMATION, SCREENING, ASSESSMENT OF NEED, CARE PLANNING, SUPPORTS COORDINATION, AND REFERRAL TO APPROPRIATE LONG-TERM CARE SUPPORTS AND SERVICES.

(H) "SINGLE POINT OF ENTRY AGENCY" MEANS THE ORGANIZATION DESIGNATED BY THE DEPARTMENT OF COMMUNITY HEALTH TO PROVIDE CASE MANAGEMENT FUNCTIONS FOR CONSUMERS IN NEED OF LONG-TERM CARE SERVICES WITHIN A DESIGNATED SINGLE POINT OF ENTRY AREA.

Health Care Association of Michigan

TO: Speaker Craig DeRoche

FROM: Reg Carter, HCAM President/CEO

DATE: April 25, 2006

RE: Single Point of Entry-HB5389

The Granholm administration is in the process of implementing a pilot program to study the effectiveness of a single point of entry system for Medicaid recipients accessing government funded long-term care services.

A pilot approach is the appropriate course of action for Michigan to take. Other states with single point of entry have experienced sharp increases in long-term care caseloads, and because single point of entry actually provides no direct health care services to individuals, it is appropriate for the state to determine whether single point of entry is worth the diversion of $60 to $72 million in taxpayer dollars away from direct patient care.

In concurrence with the pilot project, Rep. Rick Shaffer has introduced legislation to create a regulatory structure for single point of entry. This legislation seems premature and violates the integrity of the pilot study. It is as if the House has conceded that single point of entry is needed no matter what the cost and what the results of the pilot project.

The nursing home community is greatly concerned that single point of entry is a major policy change with serious fiscal implications. For these reasons, HCAM cannot support the legislation. The bill leaves room for unintended consequences:

1. A single point of entry agency should not be a provider of direct or indirect Medicaid services. Why does the legislation allow the state's Area Agencies on Aging to serve as single point of entry gatekeepers? As a group with a vested interest in the MIChoice program, this is clearly a conflict of interest.
2. The state's new criminal background check statute does not apply to the home help caregivers and single point of entry agents. Why doesn't the legislation bar all individuals with criminal histories from access to patient medical and personal information? All providers regulated under the single point of entry system should be held to the same regulatory standards when it comes to protecting our senior citizens from identity theft, fraud and abuse.
3. The legislation offers no out should single point of entry prove to be inefficient, a barrier to timely access, or cost prohibitive. Why does the legislation only require

P.O. BOX 80050 • LANSING, MICHIGAN 48908-0050 • (517) 627-1561
Member American Health Care Association

the issuance of a report in order for single point of entry to move statewide? Why doesn't the legislation require outcomes?

4. How will single point of entry be paid for? The Granholm Long Term Care Task Force estimated that single point of entry will cost between $60 and $72 million--$15 to $20 million of which would be new general fund dollars. Providers were under the impression that the Legislature wanted to reign in Medicaid spending, not inflate it. Is the Legislature planning on cutting provider rates in order to cover the cost of single point of entry?
5. The case management requirements of this legislation are huge. Case managers will be handling at least 100,000 long term care clients per year. Just a 1 to 100 ratio means that Michigan will have to contract with 1,000 caseworkers. Again, where will the money come from?
6. Nothing in the bill prohibits the Granholm administration from implementing single point of entry statewide without Legislative approval. Where is the legislative oversight?
7. Why does Michigan need this legislation when the pilots are already negotiated, bid on, and set to run this summer? If authority is needed to allow the pilots to move forward it can be granted in the DCH budget. Granting approval in the budget provides a natural sunset and allows the legislature to reevaluate its position each fiscal year.
8. If Michigan truly cares about offering as many choices as possible, then why are licensed facilities blocked from participating in single point of entry? Right now only unlicensed assisted living providers will have the chance to participate. Owners of adult foster care homes or homes for the aged cannot participate because their residents are barred from MIChoice participation.
9. What protections are there to prevent a single point of entry worker from blacklisting a nursing home provider who does not agree with the single point of entry concept? These caseworkers are not required to have medical or social work training and yet they are allowed to recommend providers. Isn't this a role better suited to physicians and nurses?
10. Over the past seven years, nursing homes have provided $375 million in uncompensated care to Medicaid recipients due to the Medicaid underfunding problem. How is it possible that Michigan can afford a $60 to $72 million program that provides no direct services? The Area Agencies on Aging claim 2,400 people currently sit on lists waiting for services. Shouldn't providing health care to people take precedence over this new layer of bureaucracy?
11. The timelines in this bill are untested and purely the result of workgroup negotiations. There are serious concerns that the timelines are unrealistic and will result in patient backups in hospitals. Hospital care is the most expensive option for most long-term care patients and discharge delays will increase hospital costs for the state. What happens when a consumer doesn't have 72 hour notice? What happens when a physician thinks his patient needs nursing home care? What happens when a patient chooses home care but the cost of home care exceeds the cost of nursing home care? None of these critical issues are addressed in the legislation.

12. Single point of entry allows government paid caseworkers to make choices that may run counter to the advice of a patient's own physician. Why does the legislation remain silent on this issue?
13. If a resident of a nursing home indicates to his or her single point of entry case manager that he or she wishes to return home, there is no consultation with a physician required. Where's the role of professional medical providers? Are taxpayers expected to foot the bill even when a consumer's choice is against medical advice?
14. Why does this bill create an Independent Consumer Advocate? Michigan already has the long term care ombudsman, the office of services to the aging, the bureau of health systems, the attorney general, the state fire marshal, the office of recipient rights, and the Center for Medicare and Medicaid Services to oversee the actions of various long-term care providers.
15. In the DCH budget all long term care services are rolled into one line item. How will the Legislature ever know if single point of entry saved the state money with these lines rolled up?

"Themed" HCAM SPE Issues
6-21-06

The Commission requested the issues raised by HCAM to be categorized into common themes.

Funding: Questions #4, #5 (also Workforce), #10, #11 (also Consumer), and #15 (also Consumer)

Consumer: Questions #11, #12, #13, #14, and #15

Provider-Based: Questions #1, #2, #8, and #9

Pilot-Based: Questions #3, #6, and #7

Workforce: Question #5

May 25, 2006

The Honorable Craig M. DeRoche
Speaker of the House
State Capitol
P.O. Box 30014
Lansing, MI 48909-7514

Dear Representative DeRoche:

I have in my possession a memorandum to you from Reg Carter, Health Care Association of Michigan President/CEO. Mr. Carter circulated this memo, dated April 25 2006, to members of the Long-term Care Supports and Services Advisory Commission on May 22. In it, Mr. Carter raises questions about House Bill 5389, Rep. Rick Shaffer's legislation establishing and regulating single points of entry. I want to answer those questions to help you in deciding whether to support Rep. Shaffer's bill.

1. HCAM argues that a single point of entry agency should not be a provider of direct or indirect Medicaid services. The bill agrees with Mr. Carter. In fact it establishes a lengthy list of conflict-of-interest provisions (many of which HCAM helped to write). On page 6 of the Substitute H-2, in subsection (5), the Department of Community Health is required to see that "the designated single point of entry for long-term care does not provide direct or contracted Medicaid services." Further, DCH must ensure that the SPE is "free from all legal and financial conflicts of interest with providers of Medicaid services."

2. HCAM says that the new criminal background checks statute does not apply to home help caregivers "and single point of entry gatekeepers." This statement is correct. And also irrelevant. Rep. Shaffer's bill regulates the DCH establishment of SPE. It cannot amend the new criminal background check statute any more than it can amend liquor laws. We would agree that the criminal background checks statutes should be changed with regard to home help caregivers, but this bill is not the place to do that.

3. HCAM says the legislation offers "no out should single point of entry prove to be inefficient, a barrier to timely access, or cost prohibitive" and asserts that the bill does not require "outcomes." This is patently untrue. Beginning on Page 7 (line 23), the bill provides an exhaustive list of criteria that an SPE must meet, or risk disqualification or other punishment. The list includes fiscal and performance standards, controls on administrative costs, identifying savings in the Medicaid budget, consumer satisfaction, quality, accessibility and availability of services.

4. How would the SPE be financed? Good question. According to the House Fiscal Agency, the money (about $60 million), would come from shifting of costs for care management services currently provided. By the way, most of those services are provided in a welter of confusing and competing care management systems that would go away once SPE-induced efficiencies occur. DCH projects that the SPE would save about 1.7 percent on the current Medicaid budget.

5. Mr. Carter says that the state will have to contract with at least 1,000 new caseworkers. He ignores the fact that the SPE will be replacing much of the work done by these caseworkers. The same dollars for case management will go to fund the SPE.

6. HCAM says there is nothing in the bill that would prohibit the Granholm administration from implementing SPE statewide without Legislative approval. He hereby stands the argument for the bill on its head. **The bill is the current legislature's chance to decide how the SPE system will work.** Without it, DCH would only have to abide by its waiver from the federal government. Thus, if it chose, the department could implement any number of "pilot" projects statewide without legislative approval. The bill caps the number of pilot projects and defines and limits administrative expenses as well as adding conflict-of-interest provisions as part of the law, not an executive order that could be changed at any time.

7. HCAM asks why the legislation is needed when the pilots are already negotiated and set to run. Mr. Carter says that authority could be granted in the budget and would provide a natural sunset. One who reads the actual bill discovers that it already requires the department to submit written reports to standing committees, appropriations subcommittees, and appropriations committee chairs, including recommendations that the program continue, be modified, or canceled. Moreover, the department would have to provide status reports as part of the annual budget process. This would happen between 12 months and 24 months after implementation of the pilots. **The bill prevents the department from going beyond the pilots until the legislature decides through the appropriations process that the program will be expanded**. Thus, the bill would do exactly what HCAM demands.

8. HCAM asks why licensed facilities are blocked from "participating" in SPE. The answer is – they are not. SPE will work with non-Medicaid patients as well. No such blockage exists. The SPE would work with the entire array of licensed, nonlicensed, facility and nonfacility based providers. The question HCAM raises more aptly should be posed about the current Medicaid waiver application filed by DCH. The state can change the Medicaid waiver; it is not an issue for the SPE bill.

9. HCAM asks whether the bill would protect against an SPE worker from blacklisting a nursing home provider who does not agree with the SPE concept. The answer is that the choice of provider is the customer's, not the SPE agent's. An SPE cannot direct anyone to a provider; it must present an array of choices. HCAM of all organizations must know that extensive federal and state laws and regulations specifically require that medical decisions remain the prerogative of facility resident customers. That value is embodied in the SPE bill.

10. HCAM sees a "new layer of bureaucracy" hidden within the SPE bill, and says the state cannot afford a "$60 [sic] to $72 million" program that provides no direct services. On the contrary, the SPE would provide the kind of direct services that consumers have long needed. Again, the funds for SPE would come from shifting of current care management resources, according to DCH.

11. HCAM raises "serious concerns that timelines are unrealistic and could result in patient backup in hospitals." He cites a 72-hour deadline for preparing a consumer support plan. He ignores the plain language of the bill, which also requires the SPE to develop a preliminary support plan within 24 hours of contact about an urgent or emergent situation in a hospital discharge. The bill also requires an SPE to "initiate contact with and be a resource to hospitals within an SPE service area." Thus, the SPE, consumer, and hospital discharge planner would have to team up to expedite services. **The expedited process could be initiated by the hospital discharge planner.**

12. HCAM asserts that the SPE allows "government paid caseworkers to make choices that may run counter to the advice of a patient's own physician." Again, the bill establishes consumer choice as the driver of care selection. SPE cannot make a choice. The bill also requires the SPE to work with a consumer or designated representative to assure that the consumer understands the entire array of choices.

13. Mr. Carter posits a situation wherein a nursing home resident can decide to return home without consultation with a physician. Again, the SPE is required to help consumers decide on a person-centered plan and to explain all options responsibly. One assumes that the consumer's physician would have contact with the consumer as part of that process, as the choice is the consumer's, not the SPE's.

14. Mr. Carter asks why the bill "creates" an independent consumer advocate. It does not. It allows a consumer through the SPE to make contact with an independent consumer advocate, which could be any office, e.g., the long-term care ombudsman, or the Office of Services to the Aging. The bill does not specify any consumer advocate.

15. Mr. Carter worries that because the DCH budget for long-term care services is rolled into one line item, the legislature would never know whether the SPE saved money. He ignores the fact that the bill requires a report to the legislature on that issue, plus many others. The House version of the DCH budget for 2006-07 unrolls the long-term care line.

Finally, we need to understand what SPE would do. The Michigan SPE like those in at least 30 other states, would provide Michigan consumers with the ability to choose long-term care services and payment options. They would replace a myriad of confusing and competing care management systems. This is extremely important when a sudden health crisis demands an instant decision and people do not know their options.

Sincerely,

William R. Knox
Associate State Director for Government Affairs
AARP Michigan
517-267-8917
wknox@aarp.org

cc: Rep. Shaffer
Rep. Vander Veen
Rep. Caswell
Sen. Hammerstrom
Sen. Cherry
Sen. Stamas

AARP Michigan

TO: LTC Supports & Services Advisory Commission
DCH Staff

FROM: Andy Farmer, Commissioner
AARP Michigan Associate State Director for Health & Supportive Services

RE: AARP Michigan Letter to House Speaker DeRoche
Responding to HCAM Concerns on House Bill 5389 – Single Point Entry

DATE: June 15, 2006

Upon receiving the HCAM presentation as public comment at our May Commission in which they memorandized their concerns on the Single Point Entry legislation (HB 5389), Bill Knox, our Associate State Director for Government Affairs, sent a point-by-point response to House Speaker DeRoche in which he detailed how HCAM concerns have indeed been previously addressed. Mr. Knox' letter is enclosed for your review and consideration.

More than just a rebuttal to HCAM's assertions, Bill wrote his letter as a direct participant in all HB 5389 Workgroup deliberations and as a witness to HCAM's direct participation in that same Workgroup.

We hope this information is helpful to you as we continue to discuss the merits of House Bill 5389 as a Commission. See you soon.

309 N. Washington Square, Suite 110 | Lansing, MI 48933 | toll-free 1-866-227-7448 | 517-482-2794 fax
toll-free 1-877-434-7598 TTY | Erik D. Olsen, President | William D. Novelli, Chief Executive Officer | www.aarp.org/mi

AARP Michigan

May 25, 2006

The Honorable Craig M. DeRoche
Speaker of the House
State Capitol
P.O. Box 30014
Lansing, MI 48909-7514

Dear Representative DeRoche:

I have in my possession a memorandum to you from Reg Carter, Health Care Association of Michigan President/CEO. Mr. Carter circulated this memo, dated April 25 2006, to members of the Long-term Care Supports and Services Advisory Commission on May 22. In it, Mr. Carter raises questions about House Bill 5389, Rep. Rick Shaffer's legislation establishing and regulating single points of entry. I want to answer those questions to help you in deciding whether to support Rep. Shaffer's bill.

1. HCAM argues that a single point of entry agency should not be a provider of direct or indirect Medicaid services. The bill agrees with Mr. Carter. In fact it establishes a lengthy list of conflict-of-interest provisions (many of which HCAM helped to write). On page 6 of the Substitute H-2, in subsection (5), the Department of Community Health is required to see that "the designated single point of entry for long-term care does not provide direct or contracted Medicaid services." Further, DCH must ensure that the SPE is "free from all legal and financial conflicts of interest with providers of Medicaid services."

2. HCAM says that the new criminal background checks statute does not apply to home help caregivers "and single point of entry gatekeepers." This statement is correct. And also irrelevant. Rep. Shaffer's bill regulates the DCH establishment of SPE. It cannot amend the new criminal background check statute any more than it can amend liquor laws. We would agree that the criminal background checks statutes should be changed with regard to home help caregivers, but this bill is not the place to do that.

309 N. Washington Square, Suite 110 | Lansing, MI 48933 | toll-free 1-866-227-7448 | 517-482-2794 fax
toll-free 1-877-434-7598 TTY | Erik D. Olsen, President | William D. Novelli, Chief Executive Officer | www.aarp.org/mi

3. HCAM says the legislation offers "no out should single point of entry prove to be inefficient, a barrier to timely access, or cost prohibitive" and asserts that the bill does not require "outcomes." This is patently untrue. Beginning on Page 7 (line 23), the bill provides an exhaustive list of criteria that an SPE must meet, or risk disqualification or other punishment. The list includes fiscal and performance standards, controls on administrative costs, identifying savings in the Medicaid budget, consumer satisfaction, quality, accessibility and availability of services.

4. How would the SPE be financed? Good question. According to the House Fiscal Agency, the money (about $60 million), would come from shifting of costs for care management services currently provided. By the way, most of those services are provided in a welter of confusing and competing care management systems that would go away once SPE-induced efficiencies occur. DCH projects that the SPE would save about 1.7 percent on the current Medicaid budget.

5. Mr. Carter says that the state will have to contract with at least 1,000 new caseworkers. He ignores the fact that the SPE will be replacing much of the work done by these caseworkers. The same dollars for case management will go to fund the SPE.

6. HCAM says there is nothing in the bill that would prohibit the Granholm administration from implementing SPE statewide without Legislative approval. He hereby stands the argument for the bill on its head. **The bill is the current legislature's chance to decide how the SPE system will work.** Without it, DCH would only have to abide by its waiver from the federal government. Thus, if it chose, the department could implement any number of "pilot" projects statewide without legislative approval. The bill caps the number of pilot projects and defines and limits administrative expenses as well as adding conflict-of-interest provisions as part of the law, not an executive order that could be changed at any time.

7. HCAM asks why the legislation is needed when the pilots are already negotiated and set to run. Mr. Carter says that authority could be granted in the budget and would provide a natural sunset. One who reads the actual bill discovers that it already requires the department to submit written reports to standing committees, appropriations subcommittees, and appropriations committee chairs, including recommendations that the program continue, be modified, or canceled. Moreover, the department would have to provide status reports as part of the annual budget process. This would happen between 12 months and 24 months after implementation of the pilots. **The bill prevents the department from going beyond the pilots until the legislature decides through the appropriations process that the program will be expanded**. Thus, the bill would do exactly what HCAM demands.

8. HCAM asks why licensed facilities are blocked from "participating" in SPE. The answer is – they are not. SPE will work with non-Medicaid patients as well. No such blockage exists. The SPE would work with the entire array of licensed, nonlicensed, facility and nonfacility based providers. The question HCAM raises more aptly should be posed about the current Medicaid waiver application filed by DCH. The state can change the Medicaid waiver; it is not an issue for the SPE bill.

9. HCAM asks whether the bill would protect against an SPE worker from blacklisting a nursing home provider who does not agree with the SPE concept. The answer is that the choice of provider is the customer's, not the SPE agent's. An SPE cannot direct anyone to a provider; it must present an array of choices. HCAM of all organizations must know that extensive federal and state laws and regulations specifically require that medical decisions remain the prerogative of facility resident customers. That value is embodied in the SPE bill.

10. HCAM sees a "new layer of bureaucracy" hidden within the SPE bill, and says the state cannot afford a "$60 [sic] to $72 million" program that provides no direct services. On the contrary, the SPE would provide the kind of direct services that consumers have long needed. Again, the funds for SPE would come from shifting of current care management resources, according to DCH.

11. HCAM raises "serious concerns that timelines are unrealistic and could result in patient backup in hospitals." He cites a 72-hour deadline for preparing a consumer support plan. He ignores the plain language of the bill, which also requires the SPE to develop a preliminary support plan within 24 hours of contact about an urgent or emergent situation in a hospital discharge. The bill also requires an SPE to "initiate contact with and be a resource to hospitals within an SPE service area." Thus, the SPE, consumer, and hospital discharge planner would have to team up to expedite services. **The expedited process could be initiated by the hospital discharge planner.**

12. HCAM asserts that the SPE allows "government paid caseworkers to make choices that may run counter to the advice of a patient's own physician." Again, the bill establishes consumer choice as the driver of care selection. SPE cannot make a choice. The bill also requires the SPE to work with a consumer or designated representative to assure that the consumer understands the entire array of choices.

13. Mr. Carter posits a situation wherein a nursing home resident can decide to return home without consultation with a physician. Again, the SPE is required to help consumers decide on a person-centered plan and to explain all options responsibly. One assumes that the consumer's physician would have contact with the consumer as part of that process, as the choice is the consumer's, not the SPE's.

14. Mr. Carter asks why the bill "creates" an independent consumer advocate. It does not. It allows a consumer through the SPE to make contact with an independent consumer advocate, which could be any office, e.g., the long-term care ombudsman, or the Office of Services to the Aging. The bill does not specify any consumer advocate.

15. Mr. Carter worries that because the DCH budget for long-term care services is rolled into one line item, the legislature would never know whether the SPE saved money. He ignores the fact that the bill requires a report to the legislature on that issue, plus many others. The House version of the DCH budget for 2006-07 unrolls the long-term care line.

Finally, we need to understand what SPE would do. The Michigan SPE like those in at least 30 other states, would provide Michigan consumers with the ability to choose long-term care services and payment options. They would replace a myriad of confusing and competing care management systems. This is extremely important when a sudden health crisis demands an instant decision and people do not know their options.

Sincerely,

William R. Knox
Associate State Director for Government Affairs
AARP Michigan
517-267-8917
wknox@aarp.org

cc: Rep. Shaffer
Rep. Vander Veen
Rep. Caswell
Sen. Hammerstrom
Sen. Cherry
Sen. Stamas

HEALTH CARE *for*
Health Care Workers

An Initiative of the Paraprofessional Healthcare Institute

Coverage for Caregivers: The Michigan Story

In February 2006, the Paraprofessional Healthcare Institute's (PHI) Health Care for Health Care Workers (HCHCW) Initiative launched the *2006 Long-Term Care Employer Survey on Health Insurance.* As a collaborative effort with the five long-term care trade associations – Health Care Association of Michigan (HCAM), Michigan Assisted Living Association (MALA), Michigan Association of Homes and Services for the Aging (MAHSA), Michigan Center for Assisted Living (MCAL), and the Michigan Home Health Association (MHHA) – this survey marks the first effort to gather information from all sectors of the long-term care industry on the availability of health insurance coverage.

While we know nationally, one in every four nursing home assistants and more than two and every five home health aides lack health insurance coverage, we do not know enough about why employer-based health insurance is out-of-reach for direct-care workers and their employers in Michigan. The following preliminary results provide a snapshot of the ability of long-term care organizations to provide health insurance coverage to direct-care workers.

PHI is continuing to collect and analyze the data and will be providing more data and information through the summer of 2006. We are pleased that these early results provide the necessary data to show what direct-care workers and employers have told us about the challenges they face in obtaining affordable, adequate, and accessible health insurance coverage. The survey will be available on-line through July 30, 2006 at http://www.zoomerang.com/survey.zgi?p=WEB224ZB3TWHF8 , or contact Tameshia Bridges at (517) 372-8310 or tbridges@paraprofessional.org to receive a copy of the survey. All responses are completely confidential.

The survey response is rich and varied with an almost 20% response rate from nursing homes and smaller responses from other segments.

- 298 surveys were completed for a response rate of 8%. The table below shows the number of responses from each employer type.

Employer	**Responses**
Adult Foster Care	172
Nursing Homes/HLTCU	83
Home Health (Certified and Private Duty)	41
Home for the Aged	37
Assisted Living	25
Hospice	10

- Respondents were geographically diverse. 30% provide services in the southeast region, 22% in the West Central region, 16% in the East Central Region, and 13% in the Southwest region. Detroit, Upper Peninsula, and Northern Lower peninsula had the lowest response had responses of less than 10%.
- Of the 172 AFC homes that responded to the survey, 33% (57) are family operated, 39% (68) are small AFC homes, and 26% (45) are large AFC homes.
- Approximately half (56%) of the employers are private, for profit organizations, one-third (33%) are private, non-profit, and about 9% are publicly-owned/operated organizations.

Overall, the long-term care employers surveyed offer comprehensive benefits to their employees.

- 61% (176) of organizations offer health insurance coverage to their workers, 112 (39%) do not.
- 83% (141) of those that offer health insurance coverage offer both family and individual coverage.
- Over 90% of organizations surveyed offer diagnostic services, inpatient hospital services, outpatient physician visits, prescription drugs, therapy services, and mental health services. 83% of organizations include disease management as a covered service.

Health insurance coverage is not available for part-time workers.

- Employers surveyed require workers to work an average of 31 hours/week to be eligible for health insurance coverage.

Health insurance is expensive for both long-term care employers and direct-care workers.

- Employer costs for health insurance are higher for long-term care organizations than the average employer costs for individual and family coverage in Michigan[1].
    - 49% of employers offering health insurance pay over $350.00.month, per employee for their contribution the full cost of coverage.
    - 62% of organizations offering family coverage pay over $800/month, per employee.
- Most organizations (60%) require employees to pay a deductible for individual and family coverage.
- Although one-in-four organizations require no employee premium for individual coverage, many organizations require a higher employee premium than the Michigan average.
    - 48% of organizations require employees to pay more than $100/month for individual coverage.
    - 64% of organizations require employees to pay over $200/month for family coverage.

Employers are concerned with the ability to continue offering coverage in the future.

- Approximately half (52%) of the organizations that currently offer health insurance coverage are concerned that they will not be able to continue doing so in the next two years.

---

[1] The average monthly employer contribution for individual coverage for all Michigan employers is $317.00 /employee and $788.00/month for family coverage. The average monthly employee contribution for individual coverage for Michigan workers is $54.44 and $171.58 for family. These averages are based on data from the 2003 average costs of health insurance plus the 11.2% increase in 2004 and 9.2% increase in 2005 for health insurance coverage. Sources: Kaiser Family Foundation. Michigan Average Annual Cost of Employment-Based Health Insurance , 2003. Available at: http://www.statehealthfacts.org and Kaiser Family Foundation/Health Research and Educational Trust. Employer Health Benefits 2005 Annual Survey. Available at: http://www.kff.org/insurance/7315/index.cfm

Larger long-term care organizations are more likely to offer health insurance coverage to their employees.

- Nursing facilities make up the largest single employer of those surveyed (45%) that offer health insurance coverage; 98% of those nursing homes responding offer coverage.
- Assisted living facilities and homes for the aged combined are the second largest employer group to offer health insurance coverage (29%).

Much like other small businesses, smaller long-term care organizations, are the least likely to offer health insurance coverage to their employees.

- Costs for workers and employers and too few employees were the primary reasons why organizations do not offer health insurance coverage.
- AFC homes represent the overwhelming majority (92.7%) of organizations that do not offer health insurance.
- When looking at types of AFC homes not offering health insurance, family adult foster-care homes represent 53% of the AFC homes not offering health insurance. Very few of the family AFC homes that responded offer health insurance coverage.
- Family AFC homes have specific characteristics that make it difficult to offer affordable health insurance to their staff – a small, primarily part-time, staff, small client base (1-6 residents), - that make it difficult to offer affordable health insurance to their staff. Family AFC homes make up one-fourth of the over 4,500 licensed AFC homes in Michigan.

We will continue to analyze and collect data through Summer 2006. Further analysis will include take-up rate and, availability of insurance and costs by organization type. The survey will remain open and available to provide an opportunity for more employers to participate. Adult foster care homes, assisted living, and home health agencies, are strongly encouraged to participate to bring the response rate up to 10% in each segment. The survey will be available on-line through July 30, 2006 at http://www.zoomerang.com/survey.zgi?p=WEB224ZB3TWHF8 , or contact Tameshia Bridges at (517) 372-8310 or tbridges@paraprofessional.org to receive a copy of the survey. All responses are completely confidential.

DRAFT #1
TEMPLATE for Progress Report to Office of LTC Supports and Services Commission

MICHIGAN MEDICAID LONG TERM CARE TASK FORCE
REPORT FROM WORKGROUP D: WORKFORCE DEVELOPMENT

Compensation Matrix of Recommendations

Principle: Michigan builds and sustains culturally competent, highly valued, competitively compensated and knowledgeable long term care workforce teams that provide high quality care within a supportive environment and are responsive to consumer needs and choices.

Goal	Strategies	***Operational Steps***	Success Measures	Barriers/Address Barriers	***Suggested Time Frame and Progress 6.06***
Compensation					
I. To ensure competitive wages/salary for long term care workers based on their level of education, experience, and responsibilities.	Economic self-sufficiency for paraprofessional staff in all long term care settings. All people working in long term care have wages comparable to the wages of other people working in health care (e.g. hospital) based on their level of education, experience and responsibilities	**Short-term Wage/Salary:** *1. Using the Lt. Governor's campaign to promote the use of the federal Earned Income Tax Credit by Michigan's low income working families, develop a strategy to engage long-term care employers in an outreach and tax assistance campaign to reach all low-income workers in long-term care.* *2. Produce and update annually a resource directory for direct care workers to identify and connect with resources to extend their income. [Examples include one created by*	Increased use of EITC by Michigan residents. Increased promotion of EITC by long-term care employers. Hits on the websites. Numbers of regionally specific resource directories created. Numbers of legislators distributing the resource	Reaching low-wage LTC workers is not easy. High cost "refund loans" diminish the dollar value of EITC refund to low-wage workers. Getting resource directory in the hands of direct care workers→ work with employers and worker organizations	**Within 6 months** *1. EITC campaign invoked by Governor's office in 2006 tax season; no known focus on any employer or low-wage worker group.* *2. No known progress statewide or regionally but for planning within the MI Quality Community Care Council for Home Help workforce*.

Goal	Strategies	***Operational Steps***	Success Measures	Barriers/Address Barriers	***Suggested Time Frame and Progress 6.06***
Compensation – Continued:	Economic self-sufficiency for paraprofessional staff in all long term care settings. All people working in long term care have wages comparable to the wages of other people working in health care (e.g. hospital) based on their level of education, experience and responsibilities	*Capital Area Community Services Inc. for Clinton, Eaton, Ingham and Shiawassee Counties and one created by Pennsylvania Department on Aging].* • Joint effort of DCH, OSA, DHS, and DLEG in collaboration with consumer, worker, employer, and • community-based organizations • Put the directory on the web within DLEG, DCH, OSA and DHS identifying it as a resource for direct care workers. • Share the directory template with all who intend to produce a local or regional directory for direct care workers or their employers • Share the template with legislators who intend to issue it regionally 3. *Compare entry and average direct care worker incomes to financial eligibility criteria*	directory Reductions in the number of uninsured direct care workers. Changes in eligibility criteria to meet needs of direct care workers.	Complexity of task; lack of baseline information about the wages and benefits of direct care workers. Complexity of eligibility requirements. Reluctance of direct care workers to “accept welfare.” Reluctance of employers to offer a job and application for welfare. Same as those above.	*3. No known progress.*

Goal	Strategies	***Operational Steps***	**Success Measures**	Barriers/Address Barriers	***Suggested Time Frame and Progress 6.06***
		for food stamps, MI Child, WIC and other public assistance programs to assess responsiveness of the public assistance program to meet the needs of direct care workers to support themselves and their families.	Increased use of public benefits by eligible families.		
Compensation – Continued:	Economic self-sufficiency for paraprofessional staff in all long term care settings. All people working in long term care have wages comparable to the wages of other people working in health care (e.g. hospital) based on their level of education, experience and responsibilities	**Long-term Wage/Salary** 4. *Using the Center on Medicare and Medicaid Services (CMS) "Return on Investment Calculator: A Tool for Analyzing State Investment in Direct Care Wages" and any other similar tools, analyze the overall economic costs and economic benefits to the State of Michigan and state programs (Medicaid, TANF, food stamps, child care, etc.) for a state-funded increase in direct care worker wages. [posted at www.hcbs.org]*	Information that documents the "true" costs of increasing the compensation of publicly funded long-term care workforce.	Complexity Political will to address some segment of the uninsured.	**Within 9 months** *4. Some use of the calculator by non-governmental groups. No use by state known.*
		5. *Re-design Medicaid reimbursement methodologies for all long-term care services to support wage rates that attract a sufficient quantity*	New reimbursement systems that recognize the connection between compensation and retention/recruitment. Higher retention rates.	Complexity. Tension between investing in compensation for the LTC workforce while also investing in more options for	**Within 4 years.** 5. *Executive proposal to increase wages of Home Help providers. Senate concurred. House limited increase to non-family*

Goal	Strategies	***Operational Steps***	Success Measures	Barriers/Address Barriers	***Suggested Time Frame and Progress 6.06***
Compensation – Continued:	Economic self-sufficiency for paraprofessional staff in all long term care settings. All people working in long term care have wages comparable to the wages of other people working in health care (e.g. hospital) based on their level of education, experience and responsibilities	*and quality of individuals to long-term care employers so that services authorized to meet consumers' needs can actually be delivered. Models and elements include:* • New methodologies could be based on "living wage" or "economically self-sufficient wage" concept. [Economic Self-Sufficiency in Michigan, A Benchmark for Ensuring Family Well-Being by the Michigan League for Human Services] • New methodologies could be based on authorizing wage rates that are needed to attract workforce and provide authorized services. [Ball vs. Biedess, U.S. District Court for Arizona, • Mechanisms to insure that authorized wage rates are implemented by employers. • Incentives based on positive workforce outcomes…retention, consumer satisfaction,	Increased consumer satisfaction. Increased staff satisfaction. Authorized wages get in the paychecks of employees. Reductions in turnover or use of pool agencies; improvements in retention, staff satisfaction, consumer satisfaction	consumers.	*providers and proposed a 2% wage increase for direct care workers within CMH system. DCH appropriations in conference process.*

Goal	Strategies	***Operational Steps***	Success Measures	Barriers/Address Barriers	***Suggested Time Frame and Progress 6.06***
		workforce satisfaction, career ladders and advancement, reduction in use of pool agencies			
II. To provide comprehensive affordable health care coverage for workers and their families.	All people working in long term care have access to health care coverage comparable to the coverage options of other people working in health care (e.g. hospital) based on their level of education, experience and responsibilities Stabilize and support employers who are offering affordable health care coverage to direct care workers and their families Utilize existing sources of coverage (Medicare, MI Child Care, third share plans, Veterans) as an interim step to provide short-term coverage and learn about the viability of new or enhanced public and employer- sponsored options. Expand the ability of long-term care employers and their part-time long-term care workers to access affordable health care coverage for themselves	**Short-Term Health care coverage:** 1. *Examine the barriers to affordable, accessible health care coverage for long-term care employers and their workforces within the DCH "Michigan State Planning Grant for the Uninsured" by over sampling both long-term care employers and direct care workers in all analysis conducted by the grant*. *2. Compare entry and average direct care worker incomes to financial eligibility criteria for public and private health assistance programs to assess the public assistance programs abilities to meet the needs of direct care workers and their families.* *3. Based on the findings in #2 immediately above, expand or target outreach to direct care workers and their employers for MI Child,*	Over-sampling of direct care workers and long-term care employers in the DCH state planning grant for the uninsured. Changes in eligibility criteria to meet needs of direct care workers. Increased use of public benefits by eligible families.	Needs of other uninsured populations Complexity Cost Public is unaware of the lack of health care coverage for long-term care workforce.	**Within 6 months** *1.DCH state planning grant activities surveyed the "uninsured" and "employers." Methodologies did not allow for identification of LTC workforce or employers. Surveys findings to be released soon.* *LTC trade associations and PHI conducted survey of organizations about health insurance barriers. Preliminary results available.* **Within 1 year** *2. No known progress* *3. Some Third Share plans have begun to examine their eligibility criteria vis-à-vis LTC and*

Goal	Strategies	***Operational Steps***	**Success Measures**	Barriers/Address Barriers	***Suggested Time Frame and Progress 6.06***
Compensation--- **Health care coverage**	and their families.	*Medicare, third share plans, Medicaid, and other public/private health care coverage options.* *4. Explore the costs and benefits of instituting a Health Insurance Premium Assistance Program (HIPP) [See http://www.cthealthpolicy.org/pubs/premium.htm for a description of the program and issues considered in CT.]* ***Long-Term Health care coverage:*** *5. Using the information collected in #1 above, re-design Medicaid and other long-term care reimbursement methodologies for all long-term care services to the recognize the costs of affordable health care coverage of the long-term care workforce so that services authorized to meet consumers' needs can be actually delivered.* *6. Using the information collected in #1 above, create health care coverage model(s) to address barriers faced by part-time direct care*	New reimbursement systems that recognize the connection between compensation and retention/recruitment. Reductions in turnover or use of pool agencies; improvements in retention, staff satisfaction, consumer satisfaction New systems that reduce the numbers of uninsured part-time workers. Higher retention rates, particularly in home care.	Needs of other uninsured populations Complexity Cost Public is unaware of the lack of health care coverage for long-term care workforce.	*DCW issues. No other known progress.* *4. No known progress.* ***Other Progress:*** *MI First Health Plan: Governor initiated planning process for federal waiver to offer a health insurance product to 550,000 people living below 200% of poverty ($19,600 for a single person; $40,000 for a family of 4). DCH now seeking stakeholder input.* **Within 4 years** *5. No known progress.* *6. Issue of part-time or multiple employer workforce identified to DCH MI First planning team.*

Goal	Strategies	***Operational Steps***	Success Measures	Barriers/Address Barriers	***Suggested Time Frame and Progress 6.06***
		workers and their employees such as "Professional Employer Organizations (PEOs); expanded Taft-Hartley funds, and other pooling strategies			
III. To promote adequate retirement planning for all employees.	Educate Employees on available programs with an emphasis on portability for employees. Educate employees on the need to plan for retirement and getting an early start.	*1. Fund a study on the business/employer barriers to funding retirement for direct care workers.* *2. Research how other small businesses that employ low income workers present retirement planning to employees and adapt to reach the direct care worker.* *3. Explore the creation of tax and other financial incentives to encourage employers to provide retirement accounts for employees.*	Study completed that identifies barriers and possible remedies		**2 years** *No known progress.*
IV. To create a Michigan business environment in support of long term care employers with an emphasis on small business, i.e. home care agencies.	Tax credits for employers who meet target level of wages and benefits. (Could more equitably implement a wage "pass through" program). Reduce the administrative burden of health	*1. Review insurance rating systems to promote access to affordable coverage for small business.* *2. Convene a health care employer round table with the State and Federal*	Insurance barriers identified and removed.		**1 year** *No known progress except as noted above*

Goal	Strategies	***Operational Steps***	Success Measures	Barriers/Address Barriers	***Suggested Time Frame and Progress 6.06***
	insurance coverage to encourage employers to provide health care coverage. Establish an insurance system that promotes access to affordable health care coverage for small business.	*small business administrations.* *3. Create a network for small business providers to access assistance with administrative functions such as health care coverage.*			

Additional workforce recommendations on recruitment, retention, culture change and workforce projections/data.